VIVID SMILES

New Patient Registration Form

Patient's Last Name _____ First _____ Middle _____

Nickname _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

Pharmacy name and cross streets:_____

EMERGENCY CONTACT

Full Name _____ Telephone _____ Relation _____

DENTAL QUESTIONNAIRE

What is your main dental concern? _____

What motivated you to make this appointment? _____

Is your current dental condition affecting any of the following (circle)? Anxiety Eating Smiling Confidence Socially

Have you seen another provider recently? If so, what was their recommendation? _____

_____

If you could wave a magic wand what would you have? _____

Are there any treatments you have researched and are interested in? _____

Any additional information you would like the doctor to know? _____

_____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist required for the initial consult, including 2D and 3D radiographs. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment, etc. Notice of Privacy Practices is available to the undersigned in paper form by request. The undersigned consents to the use and disclosure of his/her health information to carry out treatment and health care operations. The undersigned authorized representatives from Vivid Smiles and it's affiliates to use all or part of the patient's record, including written records, radiographs, photographs, videotapes, and laboratory reports for teaching and/or in promotional efforts so long as the patient is not identified by name in connection therewith. The undersigned has the right to revoke consent at any time by written notice.

Signature _____ Date _____/_____/_____

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MEDICAL HISTORY

PATIENT LAST NAME _____ **FIRST** _____ **MI**_____ **DOB** ___/____/_____

Main reason for today's visit? _____

What is your current height and weight? **Height** _____ ft _____ inches **Weight** _____ lbs

Are you **diabetic**? Yes □ No □ If yes, please select which type. Type 1 □ Type 2 □ Last A1C (date/level)? _____

Are you taking any **SSRIs**? Yes □ No □ Unsure □
******SSRIs include: Citalopram (**Celexa**), Escitalopram (**Lexapro**),Fluoxetine (**Prozac**), Paroxetine (**Paxil**, **Pexeva**), Sertraline (**Zoloft**)

Are you taking any **statins**? Yes □ No □ Unsure □
******Statins are used for high cholesterol and include:: **Lipitor, Atorvastatin, Crestor, Rosuvastatin, Zocor, Simvastatin**

Are you taking any **blood thinners**? Yes □ No □ Unsure □
******Some examples of these medications include: **Aspirin, Eliquis, Apixiban, Xarelto, Rivaroxaban, Warfarin, Coumadin, Pradaxa**

Do you **smoke**/use tobacco products? Yes □ No □ If Yes, how many packs per day? _____

Do you **smoke**/use marijuana products? Yes □ No □ If Yes, how often? _____

Have you ever taken **bisphosphonates** for **osteoporosis/brittle bones/cancer** (IV or oral)? Yes □ No □
******Some examples of these medications include: **Reclast, Boniva, Fosamax, Prolia.** If yes, please list kind/dates _____

Have you ever had cancer radiation therapy to the **head or neck**? Yes □ No □

Are you allergic to: **Penicillin** □ **Clindamycin** □ **Sulfa drugs** □ **Codeine** □ **Latex** □ **Aspirin** □ **Metal** □
Acrylic □ **Local anesthetics** □ **Other Allergy?** _____

Have you ever been hospitalized or had a major operation? Yes □ No □ If yes, please explain _____

Are you under a cardiologist's care? Yes □ No □ If yes, name and location of cardiologist: _____

Do you have any heart issues? Please explain: _____
******_Some examples include previous heart attack, mitral valve prolapse, artificial heart valve, pacemaker, heart disease, previous bypass._

Are you under a physician's care? Yes □ No □ If yes, name and location of physician: _____

Estimate of last physical exam and blood work with primary care physician or clinic ____/____/_____ □ More than 3 years ago

Please list **ALL** medications you are taking (Including supplements and over-the-counter meds):

_____

_____

Please check if you have/had:

	Yes	No		Yes	No		Yes	No
Anemia	□	□	Heart Disease	□	□	RA / Autoimmune Disease	□	
Artificial Joint(s)	□	□	High or Low Blood Pressure	□	□	Reflux / GERD / Stomach Ulcer	□	
Cancer Treatment	□	□	Kidney Disease	□	□	Sleep Apnea / CPAP Use	□	□
Depression / PTSD	□	□	Liver Disease	□	□	Sinus Issues	□	□
Diabetes	□	□	Osteoporosis / Osteopenia	□	□	Stroke or Heart Attack	□	□
Emphysema, COPD, Asthma	□	□	Pregnant / Nursing	□	□	Thyroid Disease	□	□
								□

Have you ever had an illness not listed above? If yes, please explain: _____ □

Signature _____ Date _____/_____/_____

Appointment Cancellation and Patient Financial Policy

At Vivid Smiles, we are committed to providing exceptional dental care while ensuring transparency and clarity in our financial arrangements. Please review the following cancellation and financial policy:

Cancellation Policy:
We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $75.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $75.00 cancellation fee will be charged.

Insurance Coverage:
Our office is committed to helping you maximize your benefits. because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to complexities of insurance contracts. Your estimated patient portion must be paid at time of service. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full. If you have any questions, our staff is always available to answer them.

Payment Policy:
Payment for all services is due in full prior to the commencement of any surgical procedures. We accept payment via all major credit cards, including Visa, MasterCard, American Express, and Discover.

Patient Financing:
We understand that managing dental expenses can be a concern for our patients. To provide greater flexibility and convenience, we offer patient financing options through third-party healthcare financing companies. Our team will assist you in exploring these financing options to find a solution that fits your needs.

By choosing Vivid Smiles for your dental care, you acknowledge and agree to adhere to the terms outlined in this financial policy. Should you have any questions or require further clarification, please do not hesitate to contact our office.

Patient Signature: _____ Date: _____

Patient Media and Audio Recording Consent

Consent for Audio Recording:

I hereby authorize and give my consent for the audio recording of my consultations during the course of my treatment at Vivid Smiles. I understand that these recordings are for quality assurance purposes and training purposes only. I acknowledge that this information will remain internal and will not be released to entities or individuals outside of the network of Vivid Smiles. By signing below, I waive all rights that I may have to any claims in connection with the recordings.

Consent for Photography, Filming, and Use of Patient Media:
I further consent to photography, filming, and recording of my dental surgery or post-operative appointments at Vivid Smiles. I also consent to the use of my dental radiographs, including intra-oral, CBCT, and panorex scans, for teaching, continuing education, advanced credentialing, and communication with my dental team. I understand that any use of my records will not include my name and that I will be assigned a random patient number by my dentist.

I consent to allow the photographs, radiographs, and recordings to be used for the following purposes:

- Communication with the restoring dentist, the laboratory, and myself as needed
- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals
- Marketing material, including websites and printed materials, patient education

I understand that if the photographs, radiographs, and/or recordings are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these materials.

Patient Signature: _____ Date: _____

VIVID SMILES

HIPAA Compliance Patient Consent Form

Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that: Protected health information may be disclosed or used for treatment, payment or healthcare operations The practice reserves the right to change the privacy policy as allowed by law The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease The practice may condition receipt of treatment upon execution of this consent

May we phone, email or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your dental conditions with any member of your family? YES NO

If YES, please name the family members allowed: _____

Patient Signature: _____ Date: _____