AUTHENTIC SMILES

General Information

Name: _____ I prefer to be called: _____ ☐M ☐F
Last First MI

Birth Date:_____Social Security #:_____ Marital Status: ☐ Single ☐ Married

Address: _____Cell Phone: _____

City: _____ Zip: _____Home Phone: _____

Email Address: _____ Work Phone: _____

Employer: _____ Occupation: _____

How did you hear about our office? _____

Whom may we contact in case of an emergency? _____ Phone: _____

Please list any immediate family members who are current patients: _____

Dental Insurance

Insurance Company: _____ Phone: _____

Are you the policy holder? ☐ Yes ☐ No If no, what is the policy holder's name: _____

If no, what is your relation to the policy holder? _____ Policy Holder's Birth Date: _____

Policy Holder's Social Security #: _____

Plan ID #: _____ Group #: _____

I authorize Authentic Smiles to release any information acquired in the course of my examination or treatment to my insurance company or other care providers that I have been referred to or from whom I choose to receive care. I authorize that payment be made directly to Authentic Smiles for services rendered. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account. I have read all the information on this sheet and have verified the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

*Signature of Patient/Legal Guardian *Date

Patient Name: _____ Date of Birth: _____

Medical History

Are you currently under the care of a physician? ☐yes ☐no	Are you taking or have you recently taken any prescription or over the counter medications? ☐yes ☐no
Physician's Name/Phone	If yes- please list including vitamins, natural or herbal preparations, and/or diet supplements
Physician's Address/City/State/Zip	Do you have a history of alcohol beverage abuse? ☐yes ☐no
Do you use controlled substances (drugs) ☐yes ☐no	**Women Only**:
Do you have a history of tobacco use? ☐yes ☐no Do you currently use tobacco products? ☐yes ☐no Duration?_____	Are you Taking Oral contraceptives? ☐yes ☐no Pregnant? ☐yes ☐no If yes, how many weeks? _____ Breast Feeding? ☐yes ☐no

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Dental Anesthetics ☐ Iodine ☐ Penicillin

☐Erythromycin ☐ Metals ☐ Sulfa ☐ Latex ☐ Other _____

Do you have any of the following conditions? Please check all that apply.

HENT Conditions
- ☐Hear ringing or other noises
- ☐Ear pain, discharge
- ☐Dizziness
- ☐Vision changes
- ☐Blurry vision, Double vision
- ☐Glaucoma
- ☐Runny nose, nose bleeds
- ☐Difficulty swallowing
- ☐Headache
- ☐Numbness/Tingling area on face

Cardiovascular Diseases
- ☐High Blood Pressure
- ☐Hardening of arteries
- ☐Angina
- ☐Congestive heart failure
- ☐Heart attack
- ☐Heart Bypass/Stent Surgery
- ☐Pacemaker
- ☐Valvular Prolapse
- ☐Any other heart of circulatory problems
- ☐Swollen ankles
- ☐Lower Leg Cramps

Endocrine Diseases
- ☐Diabetes
- ☐Thyroid disorder
- ☐Other Endocrine disease

Blood or Lymphatic Diseases
- ☐Anemia
- ☐Sickle Cell Disease/Trait
- ☐Bleeding disorder
- ☐HIV/AIDS
- ☐Leukemia/Lymphoma
- ☐Any other Blood disorder
- ☐Take blood thinner e.g. Coumadin
- ☐Chronic Fatigue
- ☐Easy or frequent Bruising

Respiratory Diseases
- ☐Tuberculosis
- ☐Asthma
- ☐Bronchitis, COPD, Emphysema
- ☐Sleep Apnea
- ☐Persistent cough
- ☐Shortness of breath
- ☐Wheezing
- ☐Other Lung Condition

Liver or Gastrointestinal Diseases
- ☐Hepatitis
- ☐Liver cirrhosis
- ☐Jaundice
- ☐Gall bladder stones/disease
- ☐GERD/Reflux/Ulcers/Heartburn
- ☐Constipation/Diarrhea
- ☐Blood in stool/Dark stools
- ☐Frequent Vomiting

Neurological or Mental Conditions
- ☐Stroke/TIA/Mini-stroke
- ☐Epilepsy/Seizure's
- ☐Dementia/Alzheimer's
- ☐Generalized Anxiety
- ☐Depression
- ☐Treatment for emotional condition
- ☐Any other brain/nerve condition
- ☐Other (i.e. Schizophrenia

Miscellaneous Diseases
- ☐Arthritis
- ☐Kidney Disease
- ☐Organ Transplant
- ☐Cancer
- ☐Radiation Therapy
- ☐Chemotherapy
- ☐Artificial joint/joint replacement
- ☐Sexually transmitted disease (STD)
- ☐Skin Condition
- ☐Night sweats
- ☐Fever
- ☐Unexpected weight gain/loss
- ☐High Cholesterol
- ☐ **Any other condition not listed?**

_____

Sleep and Neuromuscular

Are you a mouth breather? ☐Yes ☐No

Do you snore? ☐Yes ☐No

If yes, have you attempted treatment? (explain)

_____

Have you ever had trauma to your head or mouth? ☐Yes ☐No

If yes, please explain

_____

Have you been diagnosed with Obstructive Sleep Apnea? ☐Yes ☐No

If you have been diagnosed with Obstructive Sleep Apnea- please indicate below which treatment or therapy attempts you've made.

- ☐Pillar Procedure
- ☐Smoking Cessation
- ☐CPAP
- ☐BiPAP
- ☐Weight Loss
- ☐Uvulectomy (but continues to have symptoms)
- ☐Uvolplasty (but continues to have symptoms)
- ☐Positional Therapy (side sleeping)
- ☐other _____

Please indicate if you experience any of the following:

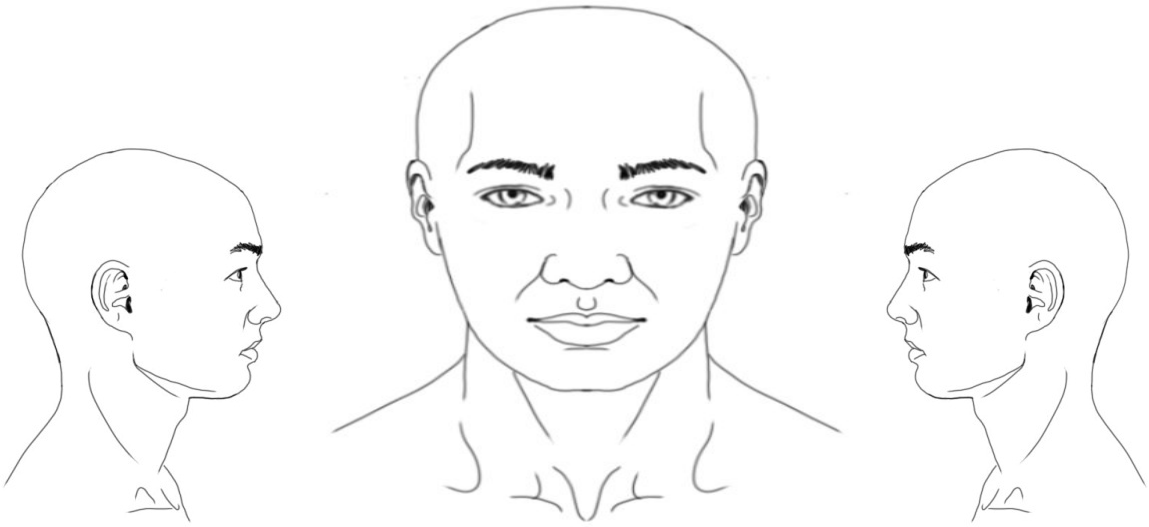
☐ Frequent Headaches ☐ Migraine Headaches ☐ Hear Ringing Noises ☐ Ear Pain ☐ Jaw Pain

☐ Neck Pain ☐ Face Pain ☐Shoulder Pain ☐ Insomnia ☐Other_____

☐ NONE OF THE ABOVE

If you are feeling any discomfort, please mark the area(s) with an (X)

Right Left



Details (time of day, frequency, ect.):

_____

_____

_____

How have you treated these symptoms?

_____

_____

_____

Do you have any disease, condition, or problem not listed above that you feel we should know about? If yes, please explain:

_____

_____

_____

Dental

Previous dentist: _____ City/State: _____
Last Visit:_____

Please rate your current dental health: ☐Good ☐Fair ☐Poor
Are you happy with your smile? ☐Yes ☐No

If no, tell us why:

_____

_____

Would you like your teeth to be whiter?	☐yes	☐no
Would you like your teeth to be straighter?	☐yes	☐no
Have you ever had orthodontics?	☐yes	☐no
Do you clench or grind your teeth?	☐yes	☐no
Are you an athlete?	☐yes	☐no
Are you interested in a nutritional lifestyle change?	☐yes	☐no

Do you experience any of the following:

☐A bad odor or taste in your mouth ☐Bleeding when brushing or flossing
☐Sensitivity to hot, cold, or sweets ☐Food trapping between your teeth

Please tell us about any of your dental concerns or information that you feel is important for us to know:

_____

_____

_____

Please tell us what you are looking for in a dental office:

_____

_____

_____

I confirm that I have read and understand the above information and that it is correct to the best of my knowledge. I understand the importance of a truthful health history and that Authentic Smiles will rely on this information when rendering treatment. I will inform Authentic Smiles if there are any change(s) in my health and/or medications.

_____ _____

*Signature of Patient/Legal Guardian *Date

Shane E. Matt DDS
211 San Antonio Street
Austin, TX 78701

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance & Accountability Act of 1966 (HIPAA). I understand that this information can and will be used to:

- Provide & coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my services.
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed that my dental provider's *Notice of Privacy Practices* contain a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice and Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is disclosed to carry out treatment, payment, or health care operations. I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Insurance and Collections

Payment is due at the time of service unless other arrangements are agreed upon. In most cases, we are able to file insurance as a courtesy to our patients. At each appointment, the patient is expected to pay the full fee for service, and will receive direct reimbursement from the insurance company. Certain necessary procedures may be excluded from coverage or considered inclusive to another procedure by your insurance company, and certain frequency limitations may apply. **The patient is ultimately responsible for any balance at Authentic Smiles and agrees to pay for the services performed regardless of insurance acceptance, denial, or reimbursement.** Please contact your insurance carrier for your benefit information as all insurance companies and plans are different.

Cancellations and No-shows

If you are unable to keep an appointment with Authentic Smiles, kindly give our office at least 24 hours notice to avoid a charge of $50.00 for hygiene appointments and $150.00 per 1 hour of appointed time with Dr. Matt or Dr. Shaw. We will make every attempt to contact you to confirm your appointment. Currently, we confirm appointments via email, text message, and phone calls in hopes that these added efforts will make your appointment confirmations easier. We ask that you please be responsible for keeping your appointment as a courtesy to our office as well as other patients. Please let us know if you have any changes in your contact information.

_____ _____

Signature of Patient/Parent if Minor Date