Patient Name: _____ Birth Date: _____

Name, Address & Phone of Physician: _____

List all medications you are taking including any over the counter, vitamin or herb supplements: _____

_____

_____

CHECK Y/N

☐ YES ☐ NO Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by any of the following (please circle): latex, penicillin, sulfa, xylocaine or other local anesthetics, general anesthesia, aspirin, codeine, foods (nuts, bananas, etc.) or any other drugs, medications or metals?_____

☐ YES ☐ NO Do you carry an epi-pen or inhaler?

☐ YES ☐ NO Have you had any excessive bleeding requiring special treatment?

☐ YES ☐ NO Do you have a family history of Malignant Hyperthermia?

☐ YES ☐ NO Do you smoke or chew tobacco?

☐ YES ☐ NO Do you have a sore in your mouth or anywhere else that has been there 10 days or longer?

☐ YES ☐ NO If female, are you pregnant?

☐ YES ☐ NO Have you been told to take an antibiotic prior to having dental treatment?

☐ YES ☐ NO Have you taken any cortisone medicines (such as Prednisone) regularly during the last 6 months?

CHECK any of the following which you have had or have at present:

☐ Heart Disease
☐ Heart Attack
☐ Any Type of Implant:
(Heart Valve, Stent, Pacemaker, etc.)
☐ History of Endocarditis
☐ Rheumatic Fever
☐ Organ Transplant
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Stroke
☐ Blood Transfusions
☐ Blood Thinners (Coumadin, Plavix, Aspirin, etc.)
☐ Thyroid Disease
Cancer (Type: _____)
☐ Chemotherapy
☐ Radiation
☐ Osteoporosis/Osteopenia
☐ Bone Mass Drugs (Oral or I.V.)
(Fosamax, Actonel, Boniva, Zometa, etc.)

☐ Tuberculosis (TB)
☐ Epilepsy or Seizures
☐ Fainting or Dizzy Spells
☐ Sinus Trouble
☐ Asthma
☐ Allergies or Hives
☐ Sexually Transmitted Diseases
☐ HIV Positive/AIDS
☐ Drug Addiction
☐ Human Papillomavirus
☐ Herpes, Genital or Oral
☐ Diabetes
☐ Arthritis
☐ Artificial Hip, Knee or Other Joint
Kidney Trouble
Hepatitis (Type: _____)
Liver Disease
Ulcers

Further explanation of any hospitalization, medical conditions or illness: _____

_____

_____

Signature: _____ Date: _____

HEALTH HISTORY

First Middle Last Nickname D.O.B. Date

Accurate answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? _____ ☐ Yes ☐ No
2. Have you ever had any serious trouble associated with previous dentistry?_____ ☐ Yes ☐ No
3. Does dental treatment make you nervous? _____ ○ No ○ Slightly ○ Moderately ○ Extremely
4. Date of last dental visit? _____
5. Have you ever been treated for periodontal disease? ☐ Yes ☐ No
   (gum disease, pyorrhea. trench mouth)?
6. Do you have or have you ever had any of the following:

Bleeding, sore gums	☐ Yes ☐ No	Loose teeth	☐ Yes ☐ No
Unpleasant taste/bad breath	☐ Yes ☐ No	Sensitive to hot	☐ Yes ☐ No
Burning tongue/lips	☐ Yes ☐ No	Sensitive to cold	☐ Yes ☐ No
Frequent blister, lips/mooth	☐ Yes ☐ No	Sensitive to sweets	☐ Yes ☐ No
Swelling/lumps in mouth	☐ Yes ☐ No	Sensitive to biting	☐ Yes ☐ No
Ortho treatments (braces)	☐ Yes ☐ No	Food impaction	☐ Yes ☐ No
Biting Cheeks/lips	☐ Yes ☐ No	Clenching/grinding	☐ Yes ☐ No
Clicking/popping jaw	☐ Yes ☐ No	If so, when? _____	
Difficulty opening or closing jaw	☐ Yes ☐ No	Change in bite	☐ Yes ☐ No
Ice chewing habit	☐ Yes ☐ No	Gag reflex:	☐ Yes ☐ No

7. Do you use the following?

Water-Pik	☐ Yes ☐ No	Dental floss	☐ Yes ☐ No
Fluoride rinse	☐ Yes ☐ No	Other: _____	
Anti-bacterial rinse	☐ Yes ☐ No	Rubber tip	☐ Yes ☐ No

8. How often do you brush? _____ Brush is:_____ ○ Soft ○ Medium ◉ Hard

These are the things that are important to me about my dental health: _____

_____

Do you have fears about dental care? If so, what: _____

_____

CIRCLE ONE:

My mouth is:
- ☐ a) very comfortable
- ☐ b) moderately comfortable
- ☐ c) uncomfortable

2. I ☐ a) think the appearance of my mouth is excellent
   - ☐ b) am satisfied with the appearance of my mouth
   - ☐ c) am dissatisfied with the appearance of my mouth

3. I think my present state of dental health is:
   - ☐ a) Excellent
   - ☐ b) Good
   - ☐ c) Poor

4. I ☐ a) have set goals for my oral health with a previous dentist
   - ☐ b) want to set goals concerning my dental health

5. I ☐ a) have always done the best that was recommended for my dental health
   - ☐ b) have not done what dentists have recommended to me
   - ☐ c) rarely go, and don't care much about having any dental work completed

6. I ☐ a) have put dentistiy for myself and my family high on my priority list
   - ☐ b) put dentistry for myself and my family lower on my priority list
   - ☐ c) put dentistry on my list but it's hard to find

7. I ☐ a) will do anything to keep my natural teeth
   - ☐ b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them

What are some questions about dentistry and oral health that you have never had adequately answered?

_____

_____

DENTAL QUESTIONAIRE

Today's Date: _____

PATIENT INFORMATION

Email: _____

Patient Name: _____ Birth Date: _____
First Middle Last

Address: _____

Home#: _____ Cell # _____ Work # _____

Marital Status: _____ Spouses Name: _____

Patient's Employment: _____

Parent/ Guardian Name: _____

Will you be paying by: CASH _____CHECK _____CREDIT CARD _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ Insured's SS#: _____ DOB:_____

Insured's Employer: _____

Insured's Employer Address: _____

Dental Insurance Company: _____

Dental Insurance Address: _____

Dental Insurance Phone #: _____Group ID #_____

Patient Covered by second dental insurance? YES NO IF YES COMPLETE FOLLOWING

Insured's Name: _____ Insured's SS#: _____ DOB:_____

Insured's Employer: _____

Insured's Employer Address: _____

Dental Insurance Company: _____

Dental Insurance Address: _____

Dental Insurance Phone #: _____Group ID #_____

EMERGENCY NOTIFICATION INFORMATION

In case of emergency, who should be notified?

Name: _____ Relationship: _____ Phone:_____

Address: _____
Street City State Zip

REGISTRATION FORM

Smile Solutions, LLC

98 Silver St.

Waterville, ME 04901

Dr. Joseph Dumont, D.D.S., Jay Wietecha D.M.D., M.A.G.D.

Peter Vayanos, D.M.D.

FINANCIAL AGREEMENT

Insurance

If you have dental insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our insurance policy. You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. Please assist us in complying with your insurance requirements by keeping us up to date with your most current information. We will gladly submit fees for your covered dental services to your insurance company; however, we expect your co-payment at the time of service.

It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits; including pre-certifications, referral, and authorization requirements and to be sure all information is correct. If you give us the wrong insurance information and a referral is required, you will be responsible for the charges. We will, however, assist you to ensure that all plan requirements are met. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to all patients, all charges are ultimately your responsibility from the date services are rendered.**

Payment for Services

Payment for services including insurance co-payment or self-pay balance amount, is due at the time services are rendered. We accept most credit cards, including Care Credit as well as checks and cash payments. Returned checks will result in a $25 fee that will be posted to your account. Returned check, balances older than 60 days, and failure to pay account balances may be subject to external collection and additional collection fees, monthly interest, including attorney and other court costs. Interest will be accrued in the amount of 1.5% for every month the balance is overdue.

General

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We must empathize that as dental care providers, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Cancelled Appointments

Charges may be incurred for broken, confirmed appointments and appointments cancelled without 24 hours notice. Your cooperation in cancelling your scheduled appointment well in advance shows us the opportunity to offer your appointment to another person in need of dental care. **Failure to show for a scheduled, confirmed appointment may result in a $50 cancellation fee.**

If you have any questions about the above information, please do not hesitate to ask us.

Thank you!

My signature below constitutes acknowledgement and acceptance of this policy:

Patient name (printed): _____ DOB_____

Patient or guardian signature: _____Date: _____

Submit