INTERNATIONAL CENTER
FOR ADVANCED DENTISTRY
GreatestSmile.com

PATIENT REGISTRATION

Patient's Name	Birth date	Age	Sex: M F
Address	City	State	Zip
Home Ph #	*E-mail:*		
Work Ph #	Driver's License #:		
Cell Ph #	Soc Sec # (optional):		
Place of Employment:	Occupation:		
Marital Status: Single Married Separated Widow			

Person paying this bill:

Name of spouse (or parent if minor):

Spouse's (or parent's) employer | Spouse's Soc. Sec. # | Work phone #

EMERGENCY INFORMATION

Name, Address, & Telephone of A relative not living with you:

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's name	
DOB	SS#
Insured's employer	
Insurance Co	
Insurance Co Address	
Phone #	
Group #	Policy #

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Name: **Date:**

DENTAL HISTORY

Please check the following:	YES	NO
Do you smoke or use chewing tobacco or Vape?	☐	☐
How much? For how long?		
Are you having any sensitivity to hot, cold or sweet?	☐	☐
If yes, where in your mouth are you having this problem? (Please circle) Upper right Upper left Lower right Lower left		
Do you have any loose, tipped or shifting teeth?	☐	☐
Do you or have you had any mouth ulcers or cold sores?	☐	☐
Do you have any teeth or fillings breaking?	☐	☐
Do you Grind or clench your teeth?	☐	☐
Do you have any Bleeding areas in your mouth when you brush or floss?	☐	☐
Do you have any swollen or irritated areas in your mouth?	☐	☐
Do you have Headaches, earaches, neck aches or jaw joint pain?	☐	☐
Do you feel like you have Bad breath?	☐	☐
Do you Snore or has someone told you that your snore?	☐	☐
Do you currently have or have you ever had Dentures or Partials?	☐	☐
Have you had or are you currently in Braces	☐	☐
Have you had Gum treatments in the past	☐	☐

When was your last dental visit? **Were X-rays taken?**

Name of Previous Dentist: **City/State:**

If I could change my smile, I would make my teeth whiter	☐	☐
If I could change my smile, I would make my teeth straighter	☐	☐
If I could change my smile, I would close spaces	☐	☐
If I could change my smile, I would replace metal fillings with tooth colored restorations	☐	☐
If I could change my smile, I would repair chipped teeth	☐	☐
If I could change my smile, I would replace missing teeth	☐	☐
If I could change my smile, I would replace old crowns that don't match	☐	☐
If I could change my smile, I would have a smile makeover	☐	☐
If I could change my smile, I would have dental implants to replace missing teeth	☐	☐

How would you rate your current dental health? (10 being the highest)

1 2 3 4 5 6 7 8 9 10

How important is your dental health to you? (10 being the highest)

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

What is the most important thing to you about your future smile and dental health?

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Name: **Date:**

HEALTH QUESTIONNAIRE

Y	N		Y	N		Y	N		Y	N	
☐	☐	Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	Nervousness/Depression	☐	☐	Ulcers
☐	☐	Anemia	☐	☐	Emphysema/ COPD	☐	☐	Osteoporosis	☐	☐	Vascular/Arterial Issues
☐	☐	Arthritis	☐	☐	Excessive Bleeding	☐	☐	Pacemaker	☐	☐	OTHER (please list):
☐	☐	Artificial Heart Valve	☐	☐	Glaucoma	☐	☐	Para-Thyroid			
☐	☐	Artificial Joints	☐	☐	Heart Conditions	☐	☐	Radiation-Head/Neck			
☐	☐	Asthma	☐	☐	Heart Surgery	☐	☐	Seizures			
☐	☐	Back Problems	☐	☐	Hepatitis A	☐	☐	Stomach Problems			
☐	☐	Blood Disease	☐	☐	Hepatitis B	☐	☐	Stroke			
☐	☐	Bruise Easily	☐	☐	Hepatitis C	☐	☐	Swelling–Feet/Ankles	**For WOMEN Only:**		
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Stomach Problems	☐		Birth Control Pills
☐	☐	Chemotherapy	☐	☐	HIV/AIDS	☐	☐	Stroke	☐		Breast-feeding
☐	☐	Circulatory Problems	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐		**Pregnant**
☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Tuberculosis	1-3 mos	3-6 mos	6-9 mos
☐	☐	Dizziness/Fainting	☐	☐	Liver Disease						

Do you have an Allergy to any of the following?

Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Nitrous Oxide
☐	☐	Erythromycin	☐	☐	Codeine
☐	☐	Latex	☐	☐	Penicillin
☐	☐	Local Anesthetic			

Other Allergies: _____

Do you require antibiotic PRE-MEDICATION for your dental visits?

☐ **Yes** ☐ **No** *If Yes, for what reason?* _____

Have you ever taken the following medications?

Bisphosphonates ☐ **Yes** ☐ **No**

i.e: Boniva Reclast Actonel Fosamax Didrocal Other:

Anti-Coagulants (Blood thinners) ☐ **Yes** ☐ **No**

i.e: Aspirin 81mg or 325 Warfarin Xarelto Eliquis Pradaxa Heparin Other:

Are you under a physician's care ☐ **Yes** ☐ **No**

If Yes, *for what?*

Physicians Name & Phone number:

Have you been hospitalized or had any surgeries in the last 5 years? ☐ **Yes** ☐ **No**

If Yes, please explain: _____

Please list All current medications: *(Including over the counter or homeopathic)*

Patient Signature

Dentist Signature

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (a copy may be requested at the front desk). The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to review our full Notice before signing Consent. The terms of our Notice may chance. If we change our Notice, you may request a revised copy by contacting our office.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice and request a copy.
- The Practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be filed on the patient's behalf without this signed HIPAA consent form.

Information Sharing: Please list any individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, _____, have received a copy of this office's Notice of Privacy Practices and Consent to their use and disclosure of protected health information.

_____ _____

Patient Name (or guardian/caregiver) (Relationship if other than the patient)

_____ _____

Signature Date

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Patient Name: _____ **DOB:** _____

Consent for Electronic Communications

(Initial below)

I _____ DO AGREE

I _____ DO NOT AGREE

That International Center for Advanced Dentistry may communicate with me electronically at the email address and/or mobile phone number listed below. Electronic communications may include appointment reminders, special events, surveys, etc.

I understand that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the office any updates to my email address or mobile phone number and I may withdraw my consent to electronic communications any time by calling the office directly.

My most preferred method of electronic communication is: **(Initial below)**

_____ **Text messaging** **Mobile #:** _____

_____ **Email** **Email address:** _____

_____ _____

Patient Signature **Date**

Photo/Video Release Authorization

(Initial below)

I _____ DO AGREE

I _____ DO NOT AGREE

That International Center for Advanced Dentistry may use my photo's, video's and/or testimonials for the purpose of publication, promotion, illustration, advertising social media or trade in any manner or medium. I hereby release International Center for Advanced Dentistry and its legal representatives for all claims of liability relating to said photo's, video's and or testimonials. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

I understand that the practice cannot condition treatment on whether or not I sign this form. I further understand that I may revoke this authorization at any time, but it must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive.

_____ _____

Patient Signature **Date**

INTERNATIONAL CENTER
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Thank you for choosing International Center for Advanced Dentistry (ICAD). Our goal is to provide exceptional dental services and products in a comfortable and caring manner.

In order to serve you best, please read and initial the following and sign at the bottom.

Appointment Reservations

It is our pleasure to reserve your appointment time in advance exclusively for you. We will be set and ready for you at the given time of your reservation, and we ask the same commitment of you. If, for any reason, you are not able to honor your reservation, our agreement is that you will contact the office during OUR REGULAR business hours a Minimum of **48 hours in advance**, so that we may care for another guest.

Initial_____

Payment of Services

You acknowledge that payment is due when services are rendered, with a **minimum 50% deposit at time of scheduling**. Parents/guardians are fully responsible for all fees incurred for treatment of their child. We accept cash, checks, debit cards, Visa, MasterCard, Discover and American Express. We also offer financing through CareCredit and Lending Tree for those that qualify. All financial arrangement decisions must be made before scheduling your appointment.

Initial_____

Dental Insurance

Your policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract, so as a courtesy to you, we will gladly file your insurance claims post treatment to your carrier. Your carrier will remit all payments directly to you.

You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which can vary from one company to another. Although we may estimate your insurance benefits, we are not responsible for their final decisions. Knowledge of benefits as well as amounts, limitations, exclusions, waiting periods, etc. is YOUR responsibility. We will assist in that understanding, as best we can. Receiving services indicates your acceptance of account responsibility.

Initial_____

Returned Checks/Unpaid Balances

There will be a charge of $55 for returned checks. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for collection and/or legal charges up to 35%.

Initial_____

Missed Appointment Fee

In order to be respectful of other guest's needs, a missed appointment will be subject to a $75 cancellation fee, that may not be billed to insurance. That fee may be waived with 24-hour advanced notice during OUR REGULAR business hours at the discretion of ICAD management.

Initial _____

Print Name: _____ DOB: _____

Signature: _____ Date: _____

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COVID-19 Pandemic Emergency Dental Treatment Consent Form

I,_____, knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus.

- I have been made aware of the CDC and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months._____(Initial)
- I confirm I am seeking treatment for a condition that meets these criteria._____(Initial)

I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below:

- Fever
- Shortness of Breath
- Loss of Sense of Taste or Smell
- Dry Cough
- Runny Nose
- Sore Throat
- _____(Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 daysto anyone who has, and this is not possible with dentistry._____(Initial)

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19._____(Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days._____(Initial)

Name:_____ Date of birth: _____

Signature:_____ Date:_____

International Center for Advanced Dentistry

www.greatestsmile.com
2900 N Military Trail | Suite 175 • Boca Raton, FL 33431
info@greatestsmile.com
(561)922-0052

Credit Card Authorization Form

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Address: _____ * _____
Address 1 Address 2

_____ * ____ * ____-____ *
City State Zip Code

Credit card Number * _____

Card Identification Number * _____

Expiration Date * _____

All Information will be kept Confidential.

This credit card is required to reserve your exclusively scheduled time with our doctors and hygienists.

Please Sign and Date

Signature _____ **Date** _____

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Oral Abnormality Screening Consent Form

We are very concerned about the high incidence of oral cancer and recommend advanced screenings for EVERY patient. Even if you are a non-smoker or non-drinker you are still at risk of developing oral cancer.

Traditionally dentists and hygienists have done oral cancer screenings with the naked eye. Unfortunately most oral cancers are not visible with the naked eye until they are in the advanced stages.
We now have an advanced technology called Velscope. This will help us pinpoint and identify suspicious tissue at earlier stages before they become life threatening.

Velscope examinations are quick and painless!

I consent to having a Velscope examination. I understand I will be responsible for a fee of $25 for this screening at my visit. * ◯ Yes ◯ No

Please sign Below.

Signature _____ **Date** _____

Response Date: _____

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We will be offering you a flouride treatment at each of your Re-care appointments. The fee for this is $25.

The American dental association highly recommends flouride treatments for all patients regardless of age. It is especially important for adults for the following reasons:

1. Prevents cavities.
2. Strengthens enamel surfaces making teeth more resistant to cavities.
3. Helps to decrease tooth sensitivity.
4. Strenghtens root surfaces which are extremely vulnerable to decay as we age. Root surfaces do not have enamel to protect them so this is highly important.

I accept and consent to a flouride treatment at this visit.

◯ YES ◯ NO

Please sign below.

Signature _____ **Date** _____

Response Date: _____