YAYA SMILES

PATIENT INTAKE FORM

TODAY'S DATE:

PATIENT INFORMATION

Name (First Middle Last): _____ Birth Date: _____

Address: _____ City: _____ State: _____ ZIP _____

Email: _____ Gender: ◯ Male ◯ Female SSN: _____

Primary Phone: _____ Secondary Phone: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed Occupation: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? ◯ I live/work in area ◯ Social Media ◯ I was referred by _____

Please share any other information you would like to here: _____

_____

DENTAL INFORMATION

Previous Dentist/Dental Office: _____

Date of last dental exam/x-rays?: _____ Date of last dental cleaning? _____

How do you like your smile? (1- Poor, 5- Ideal) 1 2 3 4 5

What is your dental apprehension? ◯ Low ◯ Medium ◯ High Source of drinking water: ◯ Well ◯ City ◯ Bottle

Have you had either of the following: ◯ Orthodontic Treatment (Date: _____) ◯ Jaw Surgery (Date: _____)

Please check any of the following dental issues you are experiencing:

◯ Cavities ◯ Tooth Pain ◯ Tooth sensitivity ◯ Esthetics
◯ Severe Dry Mouth ◯ Jaw discomfort ◯ Infection ◯ Other: _____

_____

MEDICAL INFORMATION

Primary Care Physician: _____

Preferred Pharmacy name and Phone Number: _____

Have you had any major surgeries or been hospitalized in the last 2 years? ◯ Yes ◯ No

If yes, please explain: _____

Please check any of the following health conditions that you have had or currently have:

◯ Alzheimer's ◯ Bone Density Issues ◯ GERD ◯ Psychiatric (PTSD, Bi-polar, Etc.)
◯ Arthritis ◯ Cancer ◯ Heart Attack ◯ Recreational Drug use
◯ Artificial Joint ◯ Chemo/Radiation ◯ Heart Condition ◯ Thyroid Condition
◯ Autoimmune Disease ◯ COPD ◯ Hepatitis A/B/C ◯ Tobacco use
◯ Autism ◯ C-PAP machine ◯ HIV ◯ Seizures/Epilepsy
◯ Blood Condition ◯ Diabetes (Type 1 / Type 2) ◯ Liver Disease ◯ Stroke/TIA
◯ Blood Pressure (High/Low) A1C:_____ ◯ Pacemaker

Other: _____

ALLERGIES

Please check any of the following allergies that you have had or currently have:

◯ Anesthetics ◯ Aspirin ◯ Barbituates (Sleeping Pills) ◯ Codeine ◯ Sulfa Drugs
◯ Iodine/Shellfish ◯ Latex ◯ Metals ◯ Penicillin ◯ Tylenol
◯ Other: _____

_____

MEDICATIONS Please check/list any of the following medications that you are currently taking:

○ Blood Thinners ○ Bisphosphonate ○ Albuterol (Inhaler)

○ Diabetes Medication ○ Anti- Anxiety Medication ○ Blood Pressure Medication

○ Other: _____

_____

_____

FINANCIALLY RESPONSIBLE PARTY ○ Self ○ Parent ○ Spouse ○ Other _____

Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ ZIP _____

Occupation: _____ Social Sec. #: _____

PRIMARY INSURANCE INFORMATION Policy Holder Name: _____

If none write "none"

Name of Insurance Company: _____ Policy Holder DOB: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ○ Self ○ Parent ○ Child ○ Spouse ○ Other _____

SECONDARY INSURANCE INFORMATION Policy Holder Name: _____

Name of Insurance Company: _____ Policy Holder DOB: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ○ Self ○ Parent ○ Child ○ Spouse ○ Other _____

ACKNOWLEDGMENT OF PAYMENT TERMS & ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, acknowledge that I am responsible for payment of any balance owed to Yaya Smiles for services rendered. I understand that payment is due at the time of service. I further agree to the following terms regarding any overdue balances:

1. *Payment Responsibility: I understand that I am responsible for the full payment of my account balance, including any co-pays, deductibles, or amounts not covered by insurance. All estimates on treatment by*
2. *Overdue Balances: Any balance that remains unpaid for more than 90 days from the date of service will be considered overdue.*
3. *Interest Charges: I acknowledge that if my balance is overdue by 90 days or more, a 1% interest charge will be applied to the outstanding balance each month until it is paid in full.*
4. *Collection: I understand that failure to pay any overdue balance may result in my account being turned over to a collection agency, and I may be responsible for any additional fees associated with collection efforts.*

I also hereby authorize and request my insurance company to pay directly to the doctor the amount due on my claim for services rendered to me or my dependent.

By signing below, I confirm that I have read, understand, and agree to the terms of payment and overdue balance charges as outlined above.

_____ _____

Patient Signature Date

ACKNOWLEDGMENT OF CANCELLATION POLICY

I understand that all broken appointments and appointments that are not cancelled 24 hours prior to the time of the appointment are subject to a broken appointment/late cancellation fee.

_____ _____

Patient Signature Date