

SMILE CENTER

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Patient's Name _____
Last First Middle
Address _____ City _____ State _____ Zip _____
Home Ph# (____) _____ Work Ph# (____) _____ Cell Ph# (____) _____
Soc. Sec. # _____ Email _____
Sex M F Age _____ Birthdate _____ Single Married Widowed Divorced
Patient Employed by _____ Occupation _____
Business Address _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone(____) _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Person Responsible Employed By _____ Occupation _____
Business Address _____ Business Phone (____) _____
Insurance Company _____ Group # _____
Insurance Co. Address _____ Phone (____) _____
Is patient covered by additional dental insurance? Yes No
If yes, please complete the following secondary insurance information.
Insured's Name _____ Relation to Patient _____
Insured's Soc. Sec. # _____ Insured's Birthdate _____
Insurance Company _____ Group # _____
Insurance Co. Address _____ Phone (____) _____

Please Complete Both Sides

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____ Phone (____) _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you currently under physicians care? Yes No If yes, why _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No

Taking birth control pills/Hormone Therapy Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV/AIDS/ARC | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain TMJ/TMD | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |
| <input type="checkbox"/> Circulatory Problems | | <input type="checkbox"/> Rheumatic Fever | |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. If there is any change in my medical status, I will inform the dentist. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Smile Center

Office and Financial policy

Please Read and sign at the bottom, acknowledging that you were informed of these policies. Let us know if you have any questions about our Office Policies, Thank you.

Thank you for choosing Smile Center to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

- On your first visit we expect you to supply our office with your insurance information and photo ID card. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.
- New patients are required to pay for services in full on their first visit. If the patient is a member of an HMO/DMO plan then the co-payment is due. Patients are required to pay their deductible and co-payments are at the time at of each visit.
- While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of your services covered or not covered by your individual plan.
- As a courtesy, we will gladly bill your insurance when you provide us with the current information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you either pay your portion of the bill at the time of service, or that a suitable written financial agreement be reached at the time of service. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account until it is paid in full. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. Please be aware that some, and perhaps all of the serves rendered may not be covered under individual insurance policy. You are ultimately responsible for payment of your account.
- If no payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that "This will be the final notice for payment". If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.
- Financial options are available to all patients. Please feel free to ask one of our office personnel.

Failed or Cancelled Appointments

If an appointment has been reserved for you, we kindly ask that patients give us twenty-four hours notice for cancellations; otherwise, we reserve the right to charge a minimum of \$30.00 per half hour, which is currently our broken appointment fee. The length of time reserved and the number prior failed appointments determines your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice.

Estimates and fees

After x-rays and examinations, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time diagnosed; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. There is a service charge on all unpaid accounts.

Delinquent Accounts

Delinquent accounts will have to be turned over to a Credit Reporting Collection Agency.

Notice of Privacy Practices (HIPAA)

A laminated copy of our Office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our Notice Policy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment, activates and healthcare operations. Of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and complete before signing this Consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.

Signature: _____ Date: _____

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth: _____

(Initial below)

I _____ DO AGREE

I _____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware 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 dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

_____ Text Messaging

_____ Email

I would like to receive:

_____ Appointment Reminders/Recall Visits

_____ Information regarding insurance/billing

_____ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at anytime by calling:

INSERT YOUR OFFICE NAME | PHONE NUMBER | OFFICE EMAIL ADDRESS:

Patient Signature: _____ Date: _____

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