SmilePractice
Family Dentistry

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: _____ FIRST: _____ INITIAL: _____

How do you wish to be addressed? _____ DOB _____

(☐ Single ☐ Married ☐ Divorced) (☐ Male ☐ Female) Full time Student? ☐ Yes ☐ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? ☐ Yes ☐ No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

How important is your oral health to you? _____ How much do you like your smile? _____

In a scale 1-10, (1-4 Not Important - 5-7 Somehow Important - 8-10 Very Important)

What would you change about you smile? _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

Signature _____ Date _____

PATIENT REGISTRATION

SmilePractice Family Dentistry

PLEASE COMPLETE ALL INFORMATION – THANK YOU!

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:

- ☐ Bad breath
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Smokeless tobacco
- ☐ Dry mouth
- ☐ Food collection between teeth
- ☐ Clench teeth
- ☐ Grind teeth
- ☐ Growths or sore spots in mouth
- ☐ Gums swollen, tender, or bleeding
- ☐ Head, neck, or jaw pain or aches
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Orthodontic treatment
- ☐ Nitrous Oxide
- ☐ Periodontal treatment
- ☐ Sensitivity to pressure or irritants (cold, heat, sweets)

How often do you floss? _____

How often do you brush? _____

☐ Have you ever had an allergic reactions to Novocaine, local or general anesthetics?

If Yes, please explain: _____

☐ Have you had trouble from previous dental care?

If Yes, please explain what happened: _____

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Physician's address: _____

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: _____

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: _____

Pregnant? Yes ☐ Due Date? _____ Nursing? Yes ☐ Birth Control Pills? Yes ☐

Please check if you have/had:

- ☐ Allergies, hay fever, sinusitis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Asthma: Required Hospitalization
- ☐ Asthma: Used Steroids
- ☐ Bleeding abnormally with operation/surgery
- ☐ Blood Disease, Clotting Disorders
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis?
- Type: _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Any Immune Deficiency (incl. HIV/AIDS)
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapsed
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatments
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sickle Cell Anemia
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head/Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained
- ☐ Do you wear contact lenses?
- ☐ Do you consume alcoholic beverages?
- ☐ Are you currently under the care of a Physician?
- ☐ Are you allergic/sensitive to Latex?
- ☐ Allergic to penicillin, Aspirin or Other Drugs?

If Yes, please specify: _____

☐ Are you currently taking any Medications?

If Yes, please list: _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____

DENTAL & MEDICAL HEALTH HISTORY

PATIENT NAME: _____ **DATE:** _____

Smile Practice Family Dentistry is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- ***SMILE PRACTICE FAMILY DENTISTRY PROVIDES* INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

INSURANCE

Smile Practice Family Dentistry provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Smile Practice Familly Dentistry staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to Smile Practice Family Dentistry, However, if you are paid by the insurance company instead of Smile Practice Family Dentistry, then you become responsible for the total account balance and payment is expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You as a patient are always responsible for any charges that are not covered by your insurance

MEDICARE/ MEDICAID/ WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the **Smile Practice Family Dentistry** office on the date of service.

DELINQUENT PAYMENTS

Office policy after 30 days of outstanding balance the account will be handling by the collection department.

BROKEN APPOINTMENTS

At Smile Practice Family Dentistry, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily. Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment. If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 hours, you will be subject to a $50 late cancellation charge. By signing below, I agree to fulfill my obligation as a patient at Smile Practice Family Dentistry and agree to the "broken appointment" fee should I not give proper notification.

Responsible Party Signature _____ **Date** _____

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

F I N A N C I A L P O L I C Y