Welcome to Smile360 Family Dentistry

Date: _____ How did you hear about us? _____

Patient's Name:_____ SSN: _____ Birthday: _____

Sex: Male/Female Marital Status: Minor_____Single_____Married_____Separated_____Divorced_____Widowed_____

Address: _____City:_____ State:_____ Zip:_____

Cell Number: _____ Receive text message(s)? Yes/No Home Phone Number: _____

Email address: _____ Receive email(s)? Yes/ No

Emergency Contact Name: _____ Phone # :_____

Employer: _____Occupation: _____

Spouse/Parent's Name: _____ Phone # :_____

Previous Dentist's Name and Phone # :_____

Last dental visit (date): _____ Reason for last dental visit: _____

Primary Dental Insurance

Name of insurance co: _____ Phone number: _____

Subscriber's name: _____ DOB: _____ Relationship: _____

Employer's Name: _____ SSN: _____ Subscriber ID# _____

Employer's Address: _____ Group# _____

Secondary Dental Insurance

Name of insurance co: _____ Phone number: _____

Subscriber's name: _____ DOB: _____ Relationship: _____

Employer's Name: _____ SSN: _____ Subscriber ID# _____

Employer's Address: _____ Group# _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

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DENTAL OFFICE INFORMED CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may with your agreement perform. We want to involve you in all decisions concerning invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is a risk associated with dental procedures, and all your questions have been answered. Dental treatment and procedures are not to be taken for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment. There are no guarantees that the results will be as planned and to everyone's satisfaction. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like a "filling" can lead to major complications that cannot be foreseen. For example, "Novocain" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments. The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding. infection, and other nerve problems.

I have read, understood and give my consent to dental treatments.

Signature: _____ Date: _____

Appointment Policy

When we make your appointment, we are reserving a room for your needs. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We ask that if you must change an appointment, please give us at least 48 hour notice. This courtesy makes it possible to give your reserved room to another patient who would like it. **We reserve the right to charge for any appointment(s) broken without a 48 hour notice. The charge will be $50.00 for every thirty minutes of appointment time.** ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.*** We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient you can expect us to be prompt. We of course would appreciate the same courtesy from you.

Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. We agree in writing with every patient to sign our financial policy, as we have found with our experience that this policy makes our mutual experience easier and without confusion. This policy is to ensure that all of our patients receive a highest level of quality dental care in a friendly and healthy environment while understanding their financial responsibilities. This policy as well as other health and insurance forms provided must be read, agreed to, and signed prior to any dental treatment. **Checks returned from the bank is subject to $ 35.00 service fee.** Accounts delinquent more than 60 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

Cash Patients

Patient's with no insurance are expected to pay in cash, check or credit card the day the service is rendered, unless specific arrangements are made in advance.

Insurance Patient

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I understand that I am responsible for all changes whether they are covered by insurance, as well as any additional collection costs if this office determines they are necessary.

I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested. I understand that check payments may be converted to automatic bank drafts. I have reviewed the information on this form and is accurate to the best of my knowledge.

X _____ Date: _____

(Signature of patient, parent or responsible party)

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For those patients covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% of the cost of your treatment. Majority of dental insurances cover 50% or less on many services and cover nothing on others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate as closely as possible your coverage but until we receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a pre-determination to their insurance carriers. We state what treatment you need, and they tell us what they will cover on that treatment plan. Many patients prefer to get service started immediately, and some treatments should be started immediately. In these cases, we will ask you to pay for your services in full as they are done. When the insurance company pays their portion, we will reimburse you for what they payed. We will assist you in dealing with the insurance company but ultimately the responsibility of payment and insurance problems lies with you. If we do accept assignment of benefits from the insurance company, if the insurance company hasn't paid after 45 days the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. Thank you for reading and understanding our financial policy. If you have any questions or concerns; please feel free to ask them at any time. We wish to be of assistance in any way we can.

I HAVE READ AND UNDERSTOOD THE ABOVE DENTAL OFFICE INFORMED CONSENT; *APPOINMENT POLICIES, FINANCIAL & DENTAL INSURANCE POLICIES*

_____ Date: _____

Signature of responsible party

_____

Please print your name

Dental Health History

Reason for seeking care today: Exam _____ Professional Cleaning _____ Specific problem _____

Please answer all that apply:

	Y / N		Y / N
Are you having pain/discomfort at this time?	❑ ❑	Would you like whiter teeth?	❑ ❑
Have you ever had gum treatment?	❑ ❑	Do your gums hurt or bleed when you brush?	❑ ❑
Do your teeth hurt when you chew?	❑ ❑	Have you ever had orthodontic treatment or worn braces?	❑ ❑
Are your teeth sensitive to hot, cold, sweet?	❑ ❑	Have you ever had a bad odor/taste in your mouth?	❑ ❑
Are you currently on a special diet?	❑ ❑	Do you clench or grind your teeth during the day or night?	❑ ❑
Do you have jaw joint pain or jaws feel tired?	❑ ❑	Do you mouth breathe or difficulty breathing through nose?	❑ ❑
Have you ever had full mouth x-rays taken?	❑ ❑	Would you like to have straighter teeth?	❑ ❑

When? _____

Please rate how anxious you are about dental treatment? (1= Totally relaxed, 10= Highly anxious) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

Why did you leave your previous dentist? _____

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Medical Health History: **Patients Name:** _____

Please indicate if you'd prefer to speak privately with the dentist about a medical issue? Yes_____ No _____
Physician Name: _____ City:_____Phone: _____
Are you currently seeing a physician or planning to see one for any reason? Y / N Please explain: _____
Have you been hospitalized or undergone surgery of any kind? Y / N Please describe: _____
Do you use tobacco products? What and how much: _____
Do you use alcoholic beverages? How much: _____
Do you use recreational drugs? What and how much: _____

Pre-medication

Do you have to take premedication before any dental treatment? Y / N If yes what antibiotics you are taking? _____

For women only

Are you pregnant or think you may be pregnant? Y / N Are you nursing? Y / N Are you currently taking birth control pills? Y / N

Are you allergic or have reacted adversely to any of the following medications?

Aspirin, Acetaminophen, Ibuprofen _____	Codeine, Demerol or other narcotics_____	Sulfa Drugs _____
Local anesthetics ("Novocain") _____	Penicillin or other antibiotics_____	Latex _____
Barbiturates, sedatives, etc._____	Reaction to metals_____	Nitrous Oxide _____

Others, please list: _____

Check if you have, or have you had, any of the following?

Anemia ____	Angina, Chest Pain ____	Arthritis ____
Artificial Joints ____	Artificial Heart Valve ____	Asthma ____
Blood Thinners (e.g. Coumadin) ____	Bleeding Problems ____	Cancer or Tumors ____
Chemotherapy ____	Congenital Heart Defects ____	Drug Addiction ____
Diabetes ____	Emphysema ____	Epilepsy/Seizures ____
Glaucoma ____	HIV/AIDS ____	Heart Disease or Attack ____
Heart Surgery ____	Herpes ____	High Blood Pressure ____
Hepatitis A or E ____	Autoimmune disease ____	Rapid weight loss ____
Osteoporosis ____	Hepatitis B or C ____	Hemophilia ____
Kidney Problems ____	Liver Problems ____	Low Blood Pressure ____
Lung Disease ____	Multiple Sclerosis ____	Pacemaker ____
Psychiatric Disease ____	Rheumatic Fever/Rheumatism ____	Radiation Treatment ____
Sinus Trouble ____	Sickle Cell Disease ____	Stroke ____
Thyroid Disease ____	Tuberculosis (TB) ____	Venereal Disease or/ STD ____

List any other conditions not listed above: _____ _____

If you checked on any of the above conditions, please describe in detail: _____

_____

Are you taking any medications, drug or pills? If yes, please list _____

_____

I will inform this office of any change in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, jaw necrosis, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Dentist Note: _____
Reviewed by _____Date: _____

X _____Date: _____
(Signature of Patient, Parent, or responsible party)

END