Patient Information

Patient's Name: _____ Birth date: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Please let us know how you heard about our office: _____

-Contact Information-

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ (Cellular): _____

Email address: _____May we send email appointment reminders? _____

Social Security Number_____ Driver's License Number_____

Employer Name: _____ Occupation: _____

Address: _____
Street Phone #

_____
City State Zip Code

Spouse's Name_____ Birth date_____

Employer Name: _____ Occupation: _____

Address: _____
Street Phone #

_____

-Insurance Information-

***Primary Insurance** Company Name and Address_____

Subscriber Name_____

Subscriber Social Security Number_____ Birth date _____Group Number_____

***Secondary Insurance** Company Name and Address _____

Subscriber Name_____

Subscriber Social Security Number_____ Birth date _____Group Number_____

Emergency contact: (someone other than responsible party) _____

Address:_____Phone _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Medical History

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

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back/Neck Pain
- ☐ Bulimia/Anorexia
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ GERD/ Gastric reflux
- ☐ Glaucoma
- ☐ Hay Fever

- ☐ Head Injuries
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lumps/swelling
- ☐ Osteoporosis
- ☐ Psychiatric care
- ☐ Respiratory problems
- ☐ Rheumatic fever
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis

Heart Disease-

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Artificial heart Valves
- ☐ History of infective Endocarditis
- ☐ Cardiac transplant
- ☐ Congenital heart conditions
- ☐ Pacemaker
- ☐ Heart surgery

- ☐ Artificial joints
- ☐ Blood disease
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Headaches
- ☐ HIV/ AIDS
- ☐ Jaw pain
- ☐ Radiation Treatment
- ☐ Thyroid problems
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Hemophilia
- ☐ Taking Fosamax or other bisphosphonates

Physicians Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? _____ If yes, Describe: _____

Have you ever been told you need to take an **antibiotic or pre-med** prior to your dental appointment? ☐ Yes ☐ No

If yes, please explain: _____

(**Women**) **Are you Pregnant**? ☐Yes ☐No **Nursing**? ☐Yes ☐No **Taking Birth control Pills**? ☐Yes ☐ No

Allergies

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other

Medications

List Medications you are currently taking: _____

_____

_____

_____

List Supplements you are taking:

_____

_____

Dental History

Reason for today's visit: _____ Date of last dental exam/X rays: _____

Former Dentist: _____ Phone# _____

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

- ☐ Bad Breath
- ☐ Bad dental experience
- ☐ Burning sensation on tongue
- ☐ Broken fillings
- ☐ Pierced Tongue
- ☐ Reactions to anesthetics
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat

- ☐ Chew on only one side of mouth
- ☐ Clicking, popping or locking of jaw
- ☐ Difficult extractions
- ☐ Dry mouth
- ☐ Mouth breathing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Sensitivity to sweets

- ☐ Food collection between teeth
- ☐ Grinding/ clenching
- ☐ Gums swollen/tender
- ☐ Headaches
- ☐ Jaw pain or tiredness
- ☐ Loose teeth
- ☐ Periodontal therapy/or Deep Cleaning

Gum Chewing ☐Tobacco Use

Mint/ hard candy use ☐Cigarettes ☐Pipe ☐Chew ☐Patch ☐Other

How often do you Brush? _____ How often Do you Floss? _____

- Are you happy with your smile? ☐Yes ☐No What would you like to see changed? _____

Signature

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of patient, Parent, Or Legal Guardian: _____ Date: _____

Please print name of above: _____ Relationship to patient: _____

FINANCIAL & APPOINTMENT POLICY

We are committed to providing you with the best possible care and to a trusting partnership with you in your dental care. Your clear understanding of our Financial and Appointment Policy is important to our professional relationship. Please ask if you have any question about our fees, Financial and Appointment Policy, or your responsibility at any time.

Your Payment is due at the time of treatment

Payment for treatment is due at the time services are rendered. Prepayment for all laboratory fabricated dental treatment is required (crowns, onlays, bridges, dentures, etc.). We accept most major credit cards, personal check, money orders or cash. If you prefer a deferred payment option we offer Care Credit, simply ask for a short application and/or apply online.

Dental Benefits (Insurance) – We go the extra mile

If you have dental benefits, we will make a good faith estimate of your benefits and defer billing you for that amount for up to 60 days. As a courtesy to you, we will file the appropriate claim forms with your dental benefit company. We will also track your dental claims, follow-up with your benefit provider when claims are not processed in a timely manner and attempt to expedite payment. We are also happy to provide your benefit carrier with x-rays or other information they may require in accordance with the Health Insurance Portability & Accountability Act (HIPAA).

If your dental benefit carrier denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your benefits carrier and/or your employer and your benefits provider. We will make every attempt to assist you in obtaining any benefits due you by your dental benefit provider.

For all Patients: Please help us to serve you, and our other patients, by keeping your scheduled appointments. **We do require at least 48 HOURS NOTICE for any scheduling changes to avoid an appointment charge**. To help compensate the cost of lost appointments, there will be a **broken appointment charge of $100.00.**

I understand that any delinquent balances are subject to a Finance Charge of 1% every month until balance is paid in full. Regardless of dental benefit coverage, I am responsible for the entire fee for any treatment rendered and any related expenses. I understand that I am responsible to pay reasonable attorney's fees and collection expenses incurred and expended in the event should my account be referred to an attorney or agency for collection.

Assignment and release: I authorize payment to be made directly to the dentist by my dental benefit company. I accept financial responsibility for all services whether covered or not by my dental benefit provider and I authorize release of any dental or medical care information requested by my benefit carrier.

Thank you for understanding our Financial & Appointment Policy. Please let us know if you have any questions.

_____

Patient Signature Date

_____

Responsible Party Signature if different than Patient

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

All Smiles Dentistry

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services

Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my healthcare provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my healthcare provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date:_____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

Additional Disclosure Authority: (**concluded with discussion RE: patient etc.**)

OTHER-SPECIFY Names Signatures

_____

_____

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

_____The patient refused to sign _____Communication barriers _____Emergency situation _____ Other

Patient Information- Child

Patient's Name: _____ Birth date: _____

☐ Male ☐ Female

Please let us know how you heard about our office: _____

-Contact Information-

Parent/Guardian Name: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ (Cellular): _____

Email address: _____ May we send email appointment reminders? _____

Social Security Number _____ Driver's License Number _____

Employer Name: _____ Occupation: _____

Address: _____
Street Phone #

_____
City State Zip Code

Spouse's Name _____ Birth date _____

Employer Name: _____ Occupation: _____

Address: _____
Street Phone #

_____

-Insurance Information-

***Primary Insurance** Company Name and Address _____

Subscriber Name _____

Subscriber Social Security Number _____ Birth date _____ Group Number _____

***Secondary Insurance** Company Name and Address _____

Subscriber Name _____

Subscriber Social Security Number _____ Birth date _____ Group Number _____

Emergency contact: (someone other than responsible party) _____

Address: _____ Phone _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Medical History

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

- Anemia
- Arthritis
- Asthma
- Back/Neck Pain
- Bulimia/Anorexia
- Cancer
- Diabetes
- Dizziness
- Emphysema
- Epilepsy
- Excessive bleeding
- Fainting
- Fibromyalgia
- GERD/ Gastric reflux
- Glaucoma
- Hay Fever
- Head Injuries
- Hepatitis
- High blood pressure
- *Kidney Disease*
- Liver Disease
- Lumps/swelling
- Osteoporosis
- Psychiatric care
- Respiratory problems
- Rheumatic fever
- Shortness of breath
- Sinus problems
- Sleep Apnea
- Stomach Problems
- Stroke
- Tuberculosis

Heart Disease-

- Chest pain
- Irregular heartbeat
- *Artificial heart Valves*
- History of infective Endocarditis
- Cardiac transplant
- Congenital heart conditions
- Pacemaker
- Heart surgery

- Artificial joints
- Blood disease
- Chemical dependency
- *Chemotherapy*
- Circulatory problems
- Headaches
- HIV/ AIDS
- Jaw pain
- Radiation Treatment
- Thyroid problems
- Tobacco habit
- Tonsillitis
- Hemophilia
- Taking Fosamax or other bisphosphonates

Physicians Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? _____ If yes, Describe: _____

Have you ever been told you need to take an antibiotic or pre-med prior to your dental appointment? ☐ Yes ☐ No

If yes, please explain: _____

(Women) Are you Pregnant? ☐Yes ☐No **Nursing?** ☐Yes ☐No **Taking Birth control Pills?** ☐Yes ☐ No

Allergies

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other

Medications

List Medications you are currently taking: _____

List Supplements you are taking: _____

Dental History

Reason for today's visit: _____ Date of last dental exam/X rays: _____

Former Dentist: _____ Phone# _____

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

- Bad Breath
- Bad dental experience
- Burning sensation on tongue
- Broken fillings
- Pierced Tongue
- Reactions to anesthetics
- Sensitivity to cold
- Sensitivity to heat
- Chew on only one side of mouth
- Clicking, popping or locking of jaw
- Difficult extractions
- Dry mouth
- Mouth breathing
- Orthodontic treatment
- Pain around ear
- Sensitivity to sweets
- Food collection between teeth
- Grinding/ clenching
- Gums swollen/tender
- Headaches
- Jaw pain or tiredness
- Loose teeth
- Periodontal therapy/or Deep Cleaning

Gum Chewing
Mint/ hard candy use

☐Tobacco Use
☐Cigarettes ☐Pipe ☐Chew ☐Patch ☐Other

How often do you Brush? _____ How often Do you Floss? _____

- Are you happy with your smile? ☐Yes ☐No What would you like to see changed? _____

Signature

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of patient, Parent, Or Legal Guardian: _____ Date: _____

Please print name of above: _____ Relationship to patient: _____

Dental Information- Child

Does your child have a Nickname we should use?_____

Many different things affect a child's dental health. The three most important to developing teeth are home dental care (brushing, flossing and the use of fluorides), any habits relating to the mouth or teeth, and your child's diet. To help us better evaluate your child's dental health, please answer the following questions:

HABITS

Did your child have a habit of sucking his/her thumb or finger? YES NO
Does your child chew ice? YES NO
Does your child grind his/her teeth? YES NO
Does your child have any other mouth habits? _____

HOME DENTAL CARE

When was your child's last dental appointment?_____
Any significant dental history we should be aware of?_____
_____
Does your child brush his/her own teeth? YES NO
After every meal? ____ Every Morning? ____ Every Night? ____
Do you help brush your child's teeth? YES NO
How much toothpaste does your child use? _____
Does he/she swallow it? YES NO
Does he/she use dental floss? YES NO
Does/did your child take fluoride drops or tablets? YES NO
Anything else you would like to add about the care of your child's teeth at home?
_____

DIET

Was your child put to bed with a bottle? YES NO
Does your child chew gum with sugar in it? YES NO
Is your child a "snacker"? YES NO
Would you like to make any comments about your child's diet?
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

FINANCIAL & APPOINTMENT POLICY

We are committed to providing you with the best possible care and to a trusting partnership with you in your dental care. Your clear understanding of our Financial and Appointment Policy is important to our professional relationship. Please ask if you have any question about our fees, Financial and Appointment Policy, or your responsibility at any time.

Your Payment is due at the time of treatment

Payment for treatment is due at the time services are rendered. Prepayment for all laboratory fabricated dental treatment is required (crowns, onlays, bridges, dentures, etc.). We accept most major credit cards, personal check, money orders or cash. If you prefer a deferred payment option we offer Care Credit, simply ask for a short application and/or apply online.

Dental Benefits (Insurance) – We go the extra mile

If you have dental benefits, we will make a good faith estimate of your benefits and defer billing you for that amount for up to 60 days. As a courtesy to you, we will file the appropriate claim forms with your dental benefit company. We will also track your dental claims, follow-up with your benefit provider when claims are not processed in a timely manner and attempt to expedite payment. We are also happy to provide your benefit carrier with x-rays or other information they may require in accordance with the Health Insurance Portability & Accountability Act (HIPAA).

If your dental benefit carrier denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your benefits carrier and/or your employer and your benefits provider. We will make every attempt to assist you in obtaining any benefits due you by your dental benefit provider.

For all Patients: Please help us to serve you, and our other patients, by keeping your scheduled appointments. **We do require at least 48 HOURS NOTICE for any scheduling changes to avoid an appointment charge.** To help compensate the cost of lost appointments, there will be a broken **appointment charge of $100.00.**

I understand that any delinquent balances are subject to a Finance Charge of 1% every month until balance is paid in full. Regardless of dental benefit coverage, I am responsible for the entire fee for any treatment rendered and any related expenses. I understand that I am responsible to pay reasonable attorney's fees and collection expenses incurred and expended in the event should my account be referred to an attorney or agency for collection.

Assignment and release: I authorize payment to be made directly to the dentist by my dental benefit company. I accept financial responsibility for all services whether covered or not by my dental benefit provider and I authorize release of any dental or medical care information requested by my benefit carrier.

Thank you for understanding our Financial & Appointment Policy. Please let us know if you have any questions.

Patient Signature Date

Responsible Party Signature if different than Patient

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

All Smiles Dentistry

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services

Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my healthcare provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my healthcare provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date:_____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

Additional Disclosure Authority: **(concluded with discussion RE: patient etc.)**

OTHER-SPECIFY Names Signatures

_____

_____

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:
_____The patient refused to sign _____Communication barriers _____Emergency situation _____ Other