smiles

MODERN DENTAL

Patient Full Name: _____Date:_____

Date of Birth: _____-_____-_____ Social Security: _____-_____-_____ Marital Status: Married Single Widowed

Primary Phone # to Confirm Appointments: _____- _____-_____ Alternate Phone #:_____- _____-_____

Email: _____Preferred Method for Confirming Appointments: Call Text Email

Home Street Address: _____ Apt#:_____

City: _____ State: _____ Zip Code: _____

Employer: _____ Employer Street Address: _____

City: _____ State: _____ Zip Code: _____

## Responsible Party: ☐ SELF ☐ OTHER ( If *OTHER*, please complete information below)

Name: _____ Relationship to Patient: _____

Is the Person a Patient here at Smiles Modern Dental? ☐ YES ☐ NO Marital Status: Married Single Widowed

Date of Birth: _____-_____-_____ Social Security: _____-_____-_____ Phone #: _____- _____ -_____

Email: _____Home Street Address:_____

City: _____ State: _____ Zip Code: _____

Employer: _____ Employer Street Address: _____

City: _____ State: _____ Zip Code: _____

## Insurance Information: ☐ SELF ☐ RESPONSIBLE PARTY

Insurance Company Name: _____ Insurance Phone #: _____- _____-_____

Insurance Group #_____ Alternative Insurance ID#:_____

Insurance Street Address: _____

City: _____ State: _____ Zip Code: _____

Is there Secondary Coverage: ☐ YES ☐ NO

*(Please note that we only accept primary insurance as payment, but will file your secondary insurance to reimburse you directly)*

Name of the Policy Holder for the Secondary Carrier Insurance : _____ Relationship: _____

Insurer's Date of Birth: _____-_____-_____ Insurer's Social Security#: _____-_____-_____

Insurer's Street Address: _____

City: _____ State: _____ Zip Code: _____

Insurers Employer: _____ Insurance Company Name:_____

Insurance Phone #: _____- _____-_____Insurance Group #_____ ID#_____

Insurance Street Address: _____

City: _____ State: _____ Zip Code: _____

## Referral: *How did you hear about our office?*

☐ Banner outside ☐ Ad in mail ☐Insurance ☐ Website ☐ Other: _____

☐ Another patient or friend. Their name: _____

☐ Another Doctor or Physician. Their name: _____

**A referral is the best compliment that we can receive! We pride our ourselves on being friendly, prompt, positive, and honest. We will always go the extra mile to provide the best customer service and care possible.*

# Health History Questionnaire

Medications Allergic To: _____

_____

_____

Medications Currently Taking: _____

_____

_____

Are you CURRENTLY pregnant? ☐ Yes ☐ No ☐ N/A

Do you have a LATEX Allergy? ☐ Yes ☐ No ☐ N/A

**Please check any that apply to YOU:**

| | | | | |
|---|---|---|---|---|
| ☐AIDS or HIV | ☐Dizziness | ☐Kidney Disease | ☐Radiation Treatment | ☐Anemia |
| ☐Arthritis | ☐ Drug Abuse | ☐Liver Disease | ☐Respiratory Problems | ☐Artificial Joints |
| ☐Heart Valve | ☐Epilepsy | ☐Endocarditis | ☐Rheumatic Fever | ☐Sinus Problems |
| ☐Asthma | ☐Blood Disease | ☐Blood Transfusion | ☐Hepatitis (A,B,C,D,E) | ☐Excess Bleeding |
| ☐Glaucoma | ☐Head Injuries | ☐Heart Disease | ☐Heart Murmur | ☐High Blood Pressure |
| ☐Mitral Valve Prolapse | ☐Nervous Disorder | ☐Pacemaker | ☐Penicillin Allergy | ☐Tuberculosis |
| ☐Stomach Problems | ☐Stroke | ☐Thyroid Disease | ☐Tumors | ☐Diabetes (I or II) |

☐Cancer: Type:_____ When was Diagnosis/Treatment?_____

Please clarify any positive responses from above: _____

Any other Health Problems not listed or that need clarification? ☐ Yes ☐ No If YES, *Please clarify:*_____

_____

Do you Smoke or use tobacco? ☐ Yes ☐ No I smoke/chew _____ packs/day for _____ years.

Do you experience: ☐ Head Pain ☐ Headaches ☐ Migraines ☐ Facial Pain? If **YES,** *Please mark each symptom that applies to you below:*

☐ Forehead Left or Right ☐ Cluster Headches Mexillary Sinus ☐ Occipital Headaches (back of the head)

☐ Temples Left or Right ☐ Headaches (Under the Eyes) ☐ Hair and/or Scalp Painful to Touch

Do you have TMJ Pain (difficulty/pain when opening or closing your mouth) ☐ Yes ☐ No If **YES**, *what is the frequency of the pain?*

☐ Daily ☐ Weekly ☐ Monthly ☐ After Eating **AND,** *HOW LONG* does the pain seem to last?:_____

Do you clench your teeth together under stress? ☐ Yes ☐ No ☐ Don't Know

Do you grind/clench your teeth together at night? ☐ Yes ☐ No ☐ Don't Know

Do you currently use a nightguard or snore device? ☐ Yes ☐ No If **YES**, *please specify:*_____

# Dental History

When was your last EXAM? _____ When was your last CLEANING? _____

How would you rate your fear of dental Treatment? ☐ Low ☐ Moderate ☐ Excessive

Is there anything that you would like to change about your teeth or your smile? ☐ Yes ☐ No

If **YES**, *please explain:* :_____

_____

Are you interested in whitening? ☐ In Office ☐ At home ☐ No

Is there anything you didn't like about your previous dental office that upset you? ☐ Yes ☐ No If **YES**, *please explain below*:

_____

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 doctor at the next appointment.

Signature:_____ Date:_____

# Professional Lifetime Whitening

**Promotion Includes:**

• 1 set of Professional Whitening trays with 2 tubes of professional strength whitening gel & 1 tube of whitening gel at each 6 month cleaning appointment.

**Offer Good While:**

• Dr. Willis is your current dentist, Regular 6 month cleaning appointments are kept., and Account with Smiles Modern Dental is in good standing.

Signature:_____ Date:_____

## Acknowledgement of Notice of Privacy Practices (See Clip Board for Copy)

Please check the following:

☐ I have received a copy of this Office's Notice of Privacy Practices.

☐ I have reviewed a copy of this office's Notice of Privacy Practices, but declined my copy.

Signature:_____ Date:_____

# Consent

The undersigned hereby authorizes the doctor to take radiographs, study models and photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with cleanings, fillings, crowns, dentures, extractions, etc. and further authorize and consent that the doctor choose and employ such assistance as he deems fit.

I understand that the use of anesthetic agents and certain treatments embody some risks.

In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed in an informed fashion.

I hereby give my permission to Smiles Modern Dental to release my dental records to my insurance company, specialists I may be referred to or others to whom I may request my records to be sent. I understand I have the right to view Smiles Modern Dental Privacy Notice.

I understand the responsibilities for payment for dental services provided in the office for myself or my dependents is mine and arrangements for payments are usually made before initial treatment begins. Breach of this responsibility carries the penalty of compensating the doctor(s) for attorneys and collection fees. I understand that where appropriate credit bureau reports may be obtained. Personal information is never shared with a third party and is always kept confidential.

Signature:_____ Date:_____

# Financial Policy

Payment for services is due at the time service is rendered unless the financial manager has approved payment arrangements in advance. We accept CASH, CHECKS, CARE CREDIT, MASTERCARD, VISA, AMERICAN EXPRESS, AND DISCOVER.

As a courtesy to our insured patients we will file your insurance for you and accept the assignments of benefits, however, any co-payment and deductible is due at the time of service.

Your insurance is a contract between you, your employer, and the insurance company. We will do our best to inform you of your contract benefits, but it is ultimately the patient's responsibility to be aware of the particular contract provisions of restrictions. We will not be liable for items not covered in an individual's contract. In providing proper dental care, we will assume all patients desire to complete their dental treatment needs in a timely fashion. It is the patient's responsibility to monitor their insurance maximum, and inform us if they do not wish to exceed the limit. Patients should be aware that dental treatment provided in another office will affect their insurance maximum, and our office would be unaware of such treatment performed.

Balances older than 30 days are subject to interest charges of 18% APR. Any refunds due to you will be processed monthly. Requested patient records will be released after the account balance is cleared of any balance due.

Returned checks are subject to a $25 collection fee.

Broken appointments and appointments cancelled without 24 hours notice are subject to a $50 fee.

Your name and address are never sold to a third party.

Prosthetic procedures not completed within allotted time frame might be subjected to additional lab fees.

I understand I am financially responsible for payments in full of all charges on the day of service.

Signature: _____ Date_____

# Late and Missed Appointment Policy

At Smiles Modern Dental, we put our faith in you to keep your appointment. When we set up an appointment, a specific amount of time is reserved especially for you. Many offices double or even triple book appointments to prevent from being financially damaged as a result of a missed appointment. However, double booking appointments does not allow us to give the personalized care and attention needed to provide excellent quality dentistry and for this reason *we choose to not do it.*

If for any reason you must cancel or change your appointment, it is important that you give our office **at least 24 hours notice** to offer that spot to someone else.

- **1st missed appointment:** If an appointment is missed or canceled within the 24 hour window, a letter will be sent to your home reminding you of our policy and the effects of your missed appointment. We also reserve the right to charge you up to $25 for each half hour of appointment time scheduled.

- **2nd missed appointment**: After your second missed appointment, another letter will be sent to your home notifying you of a change in status of your account. In order for you to schedule a future appointment with our doctors, a deposit must be made. The deposit is 50% of the cost of that appointments treatment or $50 whichever is greater. Upon arrival, this fee is credited toward the cost of the patient's treatment. If the patient does not show up to the appointment the deposit is non-refundable. If you choose to not pay the deposit you have the option of being placed on a short notice list and will be notified of last minute scheduling opportunities.

**For all hygiene / preventative appointments after 2nd missed appointment**, the patient will be placed on a short notice list and will be notified when there is a cancellation or opening in the schedule. No hygiene appointments can be scheduled ahead of time until the patient's account is placed back in good standing. The decision to place the patient's account back in good standing lies at the sole discretion of the office manager.

**Late arrival:** When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

I have read the policy above. I understand and agree to abide by the listed terms.

_____ _____

Signature of Financially Responsible Party Date