Patient Information

Name: (Last)_____ (First) _____ (MI)_____ Date: _____
❑ Male ❑ Female ❑ Married ❑ Single ❑ Other ❑ Child

Social Security Number: _____ Date of Birth: _____ Age: _____

Home Phone #: _____ Work/Cell Phone #: _____ Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Employer Address: _____

Referred by: ❑ Patient _____ ❑ Dental Office _____ ❑ Other _____
❑ Yellow Pages ❑ School or Work ❑ Newspaper

Date of Most Recent Dental Visit (elsewhere): _____ Reason for Today's Visit: _____

Health Information

Are you under a physician's care now? Why? _____ Phone# _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Yes No
Are you allergic to any medications or substance? Please check box below
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other _____ Yes No
WOMEN (Please check): ❑ Pregnant, # Weeks _____ ❑ Nursing ❑ Oral Contraceptives Discuss _____ Yes No

Mark box next to any condition you now have or have had in the past. For past conditions, write in month & year condition was diagnosed.
** If you now have or have had in the past any of the starred conditions, antibiotic pre-medication may be required for your dental visits.*

❑ Heart Trouble/Disease	❑ Bruise Easily	❑ Emphysema	❑ Yellow Jaundice	❑ Cold Sores/Fever Blisters
❑ *Heart Murmur **	❑ Anemia	❑ Tuberculosis	❑ Kidney Problems	❑ Herpes
❑ Irregular Heart Beat	❑ Excessive Bleeding	❑ Cancer	❑ Renal Dialysis	❑ Stroke
❑ Angina/Chest Pain	❑ Sickle Cell Disease	❑ Radiation Treatments	❑ Thyroid Disease	❑ Convulsions
❑ Heart Attack/Failure	❑ Hemophilia/Bleeding Prob.	❑ Chemotherapy	❑ Parathyroid Disease	❑ Epilepsy or Seizures
❑ Congenital Heart Disorder	❑ Leukemia	❑ Stomach/Intestinal Dis.	❑ Arthritis/Gout	❑ Fainting or Dizziness
❑ *Mitral Valve Prolapse **	❑ Recent Blood Transfusion	❑ Ulcers	❑ Rheumatism	❑ Glaucoma
❑ Scarlet Fever	❑ Swelling of Limbs	❑ Recent Weight Loss	❑ Pain in Jaw Joints	❑ Tumors or Growths
❑ *Rheumatic Fever **	❑ Lung Disease	❑ Frequent Diarrhea	❑ Cortisone Medicine	❑ Anxiety/Depression
❑ *Artificial Heart Valve **	❑ Breathing Problem	❑ Diabetes	❑ Artificial Joint/Graft	❑ Psychiatric Care
❑ *Heart Pace Maker **	❑ Shortness of Breath	❑ Excessive Thirst	❑ Venereal Disease	❑ Alzheimer's Disease
❑ Heart Surgery *	❑ Frequent Cough	❑ Hypoglycemia	❑ AIDS	❑ Allergies (Medicines)
❑ High Blood Pressure	❑ Hay Fever	❑ Liver Disease	❑ HIV Positive	❑ Allergies (Pollen/Dust)
❑ Low Blood Pressure	❑ Sinus Trouble	❑ Hepatitis A ("Contagious")	❑ Genital Herpes	❑ Hives or Rash
❑ Blood Disorder	❑ Asthma	❑ Hepatitis B or C	❑ Drug Addiction	❑ Other _____

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

Consent for Services

The health information provided above is true & correct to the best of my knowledge, & I understand that I am required to provide updates on a regular basis, or as prompted. Furthermore, I hereby give my express consent to Beautiful Smiles Family Dentistry (& any appropriately charged agents thereof) to perform dental procedures as deemed necessary to diagnose, treat &/or prevent dental conditions for the named patient. I also certify that I have the authority to complete this patient registration & give such consent considering my identity: ❑ *I am the patient, & I am 18 years of age or older*
❑ *I am the patient's legal guardian* ❑ *I have written consent of patient's legal guardian* ❑ *Other:* _____
I understand that dentistry is not an exact science & therefore no guarantees can be made about the outcome of procedures performed. Whereas certain procedures carry alternatives and/or additional risks or benefits, more specific information may be discussed with me where indicated.

X _____ _____ _____ _____
Signature of Adult Patient or Legal Guardian | Printed Name of Adult Patient or Legal Guardian | Relationship to Patient | Date

Responsible Party Information

The person named below assumes responsibility for all charges incurred & must personally sign this form.

Name: (Last)_____ (First) _____ (MI)_____ Relationship to Patient: _____

Social Security: _____ Date of Birth: _____ Age: _____

Home Phone #: _____ Work/Cell Phone #: _____ Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Employer Address: _____

X _____ _____ _____ _____
Signature of Financially Responsible Party | Printed Name of Financially Responsible Party | Relationship to Patient | Date

(CONTINUED FROM PREVIOUS PAGE)

Patient Name: (Last) _____ (First) _____ (MI) _____

Insurance Information **The person named below is the insurance subscriber & has given permission for the policy to be used.**

Plan Name & Member ID or Group #: _____

Name: (Last)_____ (First) _____ (MI)_____ Relationship to Patient: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Home Phone #: _____ Work/Cell Phone #: _____ Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Employer Address: _____

Office Financial Policies **The patient or legal guardian must read & initial each line.**

__ In consideration for dental services provided, the financially responsible party agrees to make full payment for all charges at the time of service.

__ When insurance claims are filed, the office may agree to accept only the co-payment on the date of service until the balance can be settled after claims are paid. However, it is understood that the financially responsible party is responsible for the entire account balance, regardless of whether insurance claims are filed or reimbursements received. We reserve the right to refuse service if proper personal identification is not provided.

__ Estimated insurance coverage on the Treatment Plan is based on information provided by the insurance company cannot be guaranteed by the office. Therefore insurance benefits quoted are only estimates. The quotes cannot be honored for a period of six months from the date of the patient examination & are only applicable provided the patient's condition has not deteriorated.

__ We will make every reasonable effort to collect insurance payments for the first 60 days after the date of service. However, after 60 days we reserve the right to discontinue attempts to collect insurance reimbursements. If this occurs the financially responsible party will be expected to pay the outstanding account balance within 30 days. (Documents can be provided for patients to be reimbursed directly by the insurance company.)

__ If the insurance company pays less than the estimated amount, the responsible party must pay the entire remaining balance. If an account carries a credit after all payments are received, by request, the account can be reviewed and any qualifying credit may be applied to future work or issued as a refund as indicated. In any case, a refund can never exceed the responsible party's actual out-of-pocket payment, and in some cases, a refund may be requested from the insurance company. (A refund cannot be issued for one family member if there is a balance from another family member's treatment on the same household account. We reserve the right to separate or combine family household accounts as indicated, per certain practical restrictions.) Please allow 7-10 business days for account reviews to be processed.

__ Accounts which are 90 days overdue or have dishonored payment arrangements will be referred to an outside agency for collection & charged a collection fee of $25. Any legal fees or other professional service fees incurred during the collection attempts will also be charged to the account.

__ The responsible party grants permission to the office to contact him/her by telephone or written correspondence at any contact information provided & agrees to notify the office of changes in telephone number or address.

__ In the event that any implied or accepted conditions regarding the patient's treatment or other practice policies are breached, no such breaches shall constitute grounds for reduction or dismissal of any financial obligations associated with any treatment that has already been rendered.

__ Returned checks will be subject to a $25 return check fee, and future account balances may have to be paid by cash, credit card or certified funds.

__ We reserve the right to ask patients who arrive for an appointment beyond the standard 15-minute Grace Period to reschedule the appointment. We also require 24-hours notice to cancel an appointment. There is $25 charge for appointments missed or cancelled with insufficient notice.

__ There is a $25 charge (per patient) for copies of x-rays. (With proper patient authorization, x-rays can be made available 24 hours after requested.)

Office Financial Policy Statement *I have reviewed the office financial policy statement.*

X _____ _____ _____ _____
Signature Printed Name Relationship to Patient Date

Privacy Practices Acknowledgement *I have received the Notice of Privacy Practices (HIPAA), & I have been provided an opportunity to review it.*

X _____ _____ _____ _____
Signature Printed Name Relationship to Patient Date

Emergency Contact Name _____ Relationship to Patient_____

Home Phone _____ Other Phone _____ Address _____

FOR OFFICE USE ONLY: *This document has been reviewed. Rev 050108* Signature: _____ Date: _____