

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

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

The information provided above is correct to the best of my knowledge, & I understand that I am required to provide updates on a regular basis, as prompted.

X _____
Signature Printed Name Relationship to Patient Date

Consent for Services

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 the following condition(s) regarding 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 Printed Name Relationship to Patient Date

Responsible Party Information

The person named below assumes responsibility for all financial arrangements. **If patient is responsible party, check here & skip this section:**

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: _____



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

Insurance Information

Plan Name & Member ID or Group #: _____
The person named below is the insurance subscriber. **If patient is the subscriber, check here & skip this section:**

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

- => In consideration for dental services rendered to the patient, the financially responsible party agrees to pay the reasonable value of the services to the Doctor, or his/her assignee, at the time services are rendered, or within five (5) days of billing if credit is extended. (Fees for dental services furnished are charged to the patient's account, & the financially responsible party is expected to make full payment for all charges at the time services are rendered.)
- => Our office will make every attempt to honor fees as presented on Treatment Plan estimates. However, the Treatment Plan estimated fees can only be honored for a period of six months from the date of the patient examination (provided the patient's condition has not deteriorated.)
- => As a courtesy, our office will gladly file insurance claims on behalf of the patient. 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.
- => Estimated insurance coverage on Treatment Plans is based on general information by provided by the insurance companies & cannot be guaranteed by the office. The insurance benefits quoted are only estimates and the insurance company may pay less than the estimate. If this happens, the responsible party is responsible for paying the difference on the account. Where desired or required, more accurate or specific pre-treatment estimates can be requested from the insurance company. However, this process can take up to 6 months and is still not a guarantee of payment of benefits per your insurance carrier.
- => Our office will make every reasonable effort to collect reimbursements from insurance companies for the first 60 days after the treatment date. However, we reserve the right to discontinue attempts to collect unpaid insurance reimbursements after 60 days. If this occurs, the financially responsible party will be notified & expected to pay any outstanding account balance within 30 days. (The responsible party may then submit the claim to the insurance company for direct reimbursement. If needed, our office may be able to provide some documentation to submit the claim privately.)
- => Any account balances outstanding 90 days after the date of service or (credit accounts with 2 or more missed payments) will be referred to an outside agency for collection & charged a collection fee of 20%. 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 contact information provided during patient registration & agrees to notify office of any 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.
- => There is a 15 minute grace period following a scheduled appointment. If you arrive after the grace period you will need to reschedule your appointment. There is also a \$25 Broken Appointment fee that will be applied to your account if you fail to show up for a set appointment or if you cancel an appointment with less than 24 hours notice.

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

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