Patient's Information
First Name_____ Last Name_____
Address _____City_____ State _____
Zip_____
Phone Number _____ Email Address _____
_____
Sex ☐F ☐M Date of Birth ____/____/_____Marital Status ☐ Sing☐ Marr☐d ☐
Child Other
Social Security Number _____
Employer_____
Address _____
Who may we thank for referring you (or how did you hear about us)?_____
_____

Responsible Party Information
First Name_____ Last Name_____
Relationship to Patient_____Phone Number_____
_____

Insurance Information

Insured's First Name (subscriber)_____Last Name_____
Subscriber Date of Birth ___ _/_____/_____Subscriber SSN#_____
_____
Insurance Company _____ Group #_____ID#_____
Insurance Phone Number _____

Additional Insurance Information

Do you have additional insuranc☐ ☐Y N
Insured's First Name (subscriber)_____Last Name_____
Subscriber Date of Birth ___ _/_____/_____Subscriber SSN#_____
_____
Insurance Company _____ Group #_____ID#_____
Insurance Phone Number _____
Emergency Contact Information
Name_____ Phone Number _____
Address_____ Relationship to patient_____
_____

Insurance Authorization
Please read and sign before treatment can be performed. I authorize the dentist to release my information including diagnosis and the records of my treatment or examination rendered to me and/or other health practitioners; I hereby assign all medical, dental, and/or surgical benefits to which I am entitled for this service to Friendly Smiles Dental Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that my dental insurance carrier may pay less

than the actual bill for services, and in that event I am financially responsible for all remaining balance of and/or dependents account within 60 days.

Patient Signature: _____

Medical History

Have you in the past or are you currently experiencing, being treated for or taking medications for the following:

- ☐ Acid Reflux
- ☐ Active Contested Heart Failure
- ☐ AIDS
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Artificial Heart Valve4s
- ☐ Arthritis, Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chronic Fatigue
- ☐ Chronic Lung
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up blood
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy, or Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Insomnia
- ☐ Irregular Heartbeat
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapsed
- ☐ Narcolepsy
- ☐ Nasal Congestion
- ☐ Nervous Problems
- ☐ Obstructive Sleep Apnea
- ☐ Oxygen Therapy
- ☐ Pacemaker
- ☐ Pact Strokes
- ☐ Past Heart Attack
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Restless Leg Syndrome
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

Do you require premedication? Discuss:_____
Current Medications:_____
Are you allergic to any medication?_____
Are there any medical conditions we have not discussed or listed that we should be aware of?_
_____
_____

☐ Yes☐ No Female Patients: Is there a possibility that you could be pregnant?
☐ Yes☐ No Female Patients: Are you currently nursing?
☐ Yes☐ No are you under a physician/s care?

Print Patient's Name _____ Date_____
Signature of Patient (or Legal Guardian) _____ Date_____

Friendly Smiles Dental Care

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NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1966 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ➢ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- ➢ Obtain payment from third party payers.
- ➢ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood your Notice Of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that I may conduct this organization at any time at the address below to obtain a current copy of the Notice Of Privacy Practices. 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____

Photo Consent Form

I hereby give Friendly Smile Dental Care and any and all employees and/ or agents of Friendly Smiles the right and permission to use and/ or publish photographs of me or family members for art, promotional purpose (including but not limited to, advertising, publicity, commercial or display of use).

Initial the following:

_____**Yes,** you may use my photos

_____ **No,** Please do not use my photos

Friendly Smiles Dental Care

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Signature:_____**Date:**_____

CONSENT FOR SERVICES

I hereby authorize the doctor to perform a complete exam and evaluation. I hereby authorize the doctor or designated staff member to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such assistance as required to provide proper care. I agree to be responsible for payment of all services on me or my dependents behalf. I understand that payment is due at the time of service unless other arrangements have been made. If the agreed payments are not received by upon dates, I understand that a late charge may be added to my account.

I, the undersigned, certify that I have read and understand all of the above information. Have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I have received adequate information and have had the opportunity to ask questions and all questions have been fully answered to my satisfaction. I certify that I have read, and understand the document I am signing.

AUTHORITY TO TREAT

I give Friendly Smiles Dental Care the authority to administer dental x-rays, local injections, anesthetics, and if requested of my case. If I have a medical condition such as, heart murmur that requires premedication or drug allergy, I have acknowledge that it is my responsibility to inform and remind the doctor, assistant, or hygienist every time before treatment. Please advise our office of any and all medications you may be taking especially any blood thinners (aspirin on a daily basis or Coumadin).

OFFICE POLICIES AND FINANCIAL AGREEMENT

It is our desire to make high quality dental care affordable to everyone. The following is a statement of our office policy and financial policy, which we ask that you read, agree to, and sign before any treatment is rendered.

Most dental insurance have limits and/or various degrees of co-payments. The treatment recommended by our office is never based on what your insurance will pay; your treatment should not be governed by your insurance contract.

PAST DUE ACCOUNTS

Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment the patient/guarantor is responsible for the portion the insurance does not cover. Please be aware that some insurance companies may not cover all services performed in our office. The patient/guarantor is responsible for all charges that are denied or unpaid by your insurance carrier. If for some unforeseen reasons your insurance carrier has not made a payment within 45days, the patient/ guarantor is responsible for these charges. If payment is not received within 90 days and no financial arrangement has been made, your account will be turned over to a collection agency and you will accrue 33.5% collection fee in addition to your overdue balance.

Monthly interest rate of 1.5% (18%APR) will be incurred for account 60 days past due. I agree that I am liable for all collection charges including but limited to attorney and legal fees in the event that my account was turned over to a collection agency. A fee of $25 will be

charged on all returned checks. I understand that I am financially responsible for all charges incurred in full by myself and/or my dependents.

Initials: _____

Minors

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, treatment will be denied, unless treatment and the charges have been pre-authorized from the parent or legal guardian.

CANCELLATION POLICY

If you are unable to keep and appointment, we ask that you kindly provide us with a minimum of two business days notice. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist.

MISSED APPOINTMENT FEE

Missed appointment fee of $35 will be charged to any patient who does not notify our office within two business days to cancel or reschedule their appointment.

REGARDING INSURANCE

If the patient has any insurance charges or maxed out benefits, it is the patients/guarantors responsibility to be aware of it and provide the information. If this information is not provided at the time of service the patient/guarantor will be responsible for the charges incurred.

I understand my dental insurance is a contract between the insurance carrier and the patient. Not between doctors and insurance carrier. Please note that NO individual in this office can predict exactly what amount your insurance will pay. When we verify your coverage with your insurance company, they also indicate that there is no guarantee of coverage until they receive the claim. We will only be able to give you an estimate and we cannot be held responsible to that estimate in any way. In some cases, insurance companies use alternative benefits as a method of payment and not pay the total estimated amount. Therefore, do not hold us responsible for payments that a third party may refuse to pay.

MANAGED CARE PLANS

We are not participants in any managed care, HMO or DMO

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE OFFICE POLICIES AND FINANCIAL AGREEMENTS.

Friendly Smiles Dental Care

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_____

Patient's Signature (Parent's Signature if Patient is a Minor)