# Welcome

Smile Forever
Family Dentistry

***Thank you for selecting our dental healthcare team! We will strive to provide you with best possible dental care.***

***To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have questions or need assistance, please ask us - we will be happy to help.***

## *Patient Information* (Confidential)

Date:_____

*Name*_____ *Birthdate*_____

*Name Wishes to be called*_____ *Soc. Sec. #*_____

*Address*_____ *City*_____ *State*_____ *Zip*_____

☐ *Male* ☐ *Female* ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorce* ☐ *Widowed* ☐ *Separated*

*Employer*_____ *Occupation*_____

*Referred by*_____

*Home Phone*_____ *Work Phone*_____ *ext* _____ *Cell Phone*_____

*Person to contact in case of emergency*_____

*Relationship to patient*_____ *Home Phone*_____ *Work Phone*_____ *ext*_____

## *Responsible Party* (Who is responsible for the account)

*Name*_____ *Birthdate*_____ *Home Phone*_____

*Relationship to patient*_____ *Soc. Sec. #*_____

*Address*_____ *City*_____ *State*_____ *Zip*_____

*Driver's License*_____ *Occupation*_____

*Employer*_____ *Work Phone*_____ *ext*_____

## *Dental Insurance Information*

*Name of the Insured*_____ *Relationship to Patient*_____

*Soc. Sec #*_____ *Insured's Birthdate*_____

*Name of Employer*_____ *Union or Local #* _____ *Work Phone*_____

*Address of Employer*_____ *City*_____ *State*_____ *Zip*_____

*Insurance Company*_____ *Group #*_____ *Policy/ID #*_____

*Ins. Co. Address*_____ *City*_____ *State*_____ *Zip*_____

*How Much is your deductible?*_____ *How much have you used?*_____ *Annual Benefit*_____

**ADDITIONAL INSURANCE INFORMATION** ☐ ***YES*** ☐ ***NO***

*Name of the Insured*_____ *Relationship to Patient*_____

*Soc. Sec #*_____ *Insured's Birthdate*_____

*Name of Employer*_____ *Union or Local #* _____ *Work Phone*_____

*Address of Employer*_____ *City*_____ *State*_____ *Zip*_____

*Insurance Company*_____ *Group #*_____ *Policy/ID #*_____

*Ins. Co. Address*_____ *City*_____ *State*_____ *Zip*_____

*How Much is your deductible?*_____ *How much have you used?*_____ *Annual Benefit*_____

# *Authorization and Release*

*I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.*

*I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.*

*I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

***X*** _____

*Signature of patient or parent of minor* *Date*

# *Financial Arrangement*

*For your convenience, we offer the following methods of payment. Please check the option which you prefer.*
*PAYMENT IN FULL AT EACH APPOINTMENT.*

_____*Cash*
_____*Personal Check*
_____*Credit Card* _____*Visa* _____*MC*

_____*I wish to apply for credit*

# *Late Charges*

*If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.*

***Thank you for filling out this form completely. The information you provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.***

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# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | High Cholesterol ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Osteoporosis ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pacemaker ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| | | | Yellow Jaundice ◯ Yes ◯ No |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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## *Insurance and Financial Policy*

At SMILE FOREVER, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know… … …

Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."**

We bill your insurance as a courtesy. If insurance does not pay within 90 days, SMILE FOREVER reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

SMILE FOREVER does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and cashier checks, money orders, and personal checks under $500.00.. We **accept** personal checks over $500.00 for existing patients with established payment history only . If you are in need of an extended finance option, we also work with **Care Credit**, who offers a 3-12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of the patient services staff for an application.

**Broken Appointments:** A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **$35/hour cancellation fee** (emergencies are an exception).

**After Hours/Weekend Emergencies:** In the event of an emergency after regular business hours a **$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$125 after hours emergency fee**.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

**Print:** _____

**Sign:** _____

# SMILE FOREVER

9873 BRIDGEPORT WAY SW SUITE A • LAKEWOOD, WA 98499

## NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting

**PHONG DANG, DDS**
**9873 BRIDGEPORT WAY SW SUITE A**
**LAKEWOOD, WA 98499**
**TEL: 253.588.6208 • FAX: 253.582.0626**

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

Patient Name

Patient or legally authorized individual signature

Date Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

ADDITIONAL NOTES:

This form will be retained in your medical record.

Last Update:___/___/___