Patient Information

Patient Name: _____ Date _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____
Social Security #:_____ Birth Date: _____
Phone Home: _____ Work: _____ Cell: _____
Email Address: _____
Address: _____
Street State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV	☐ Blood Thinners	☐ Heart Disease	☐ Stroke
☐ Anemia	☐ Cancer/Tumor	☐ Heart Murmur	☐ Sinus Problems
☐ Angina	☐ Diabetes	☐ Hepatitis Type_____	☐ Thyroid Problems
☐ Arthritis	☐ Dizziness/Fainting	☐ High/Low Blood Pressure (Which)	☐ **Pregnancy**
☐ Artificial Joints	☐ Epilepsy/Seizures	☐ Pacemaker	Due date: _____
☐ Asthma/Cough	☐ Headaches	☐ Radiation Treatment	

Do you have any disease, mental or health condition or problem not listed? _____
Are you **ALLERGIC** to ☐ **Penicillin** ☐ **Codeine** ☐ **Local Anesthetic** (injected) _____
Are you sensitive to any? ☐ **Metals** ☐ **Latex**

Please list medications that you are taking if any?

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
Name of Physician: _____ Phone: _____

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 doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral information

Who may we thank for referring you? _____

Spouse or Responsible Party

(If Different from patient)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone Home: _____ Work_____ Ext_____ Best time to call: _____

Address: _____

Street Apartment

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #:_____

Insured's Employer Name: _____ Group #: _____

Insurance Company Name: _____ Insurance Phone #: _____

Insurance Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by insurance company. Patients is fully responsible for any payment sent to them by the insurance company for services rendered by our office and must notify the dental office to endorse payment to the office.

A service charge of 35% on the unpaid balance will be charged on all accounts extended for a period of six months from the date of the examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible Party

Office and Financial Policies

Welcome to Smile Image Dentists and thank you for choosing us for your dental care. We are committed to providing you with the highest quality dental care, in an efficient, timely and cost effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

Initial____ Insurance: IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL POLICY COVERAGE! YOUR POLICY IS BETWEEN YOU AND THE INSURANDE COMPANY. WE FILE YOUR CLAIM AS A COURTESY. Due to the many variations in insurance policies, it is no longer an easy task to interpret each individual policy (this includes HMO'S and PPO'S). Although we try very hard to stay aware of these changes, it is not always possible. If a procedure or service is performed that is not covered, or we were given wrong information from your carrier in reference to your benefits, you will be responsible for that charge. Therefore, we urge you, the patient, to please verify your benefits (as we do) prior to any dental treatment. You need to VERIFY THAT THE PROCEDURE/DIAGNOSIS IS COVERED by your insurance company. Many companies exclude particular diagnose (such as nitrous oxide, crown build-up, full mouth debridement, and others) depending on your policy. Your failure to verify insurance covered could result in you being responsible for all cost. We at Smile Image will make every effort to verify and assist you in obtaining this information.

Initial_____ Late Arrivals: We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 min. past your scheduled appointment time, you will be rescheduled so that other patients are not inconvenienced

Initial_____ No Shows and Late Cancellations: We require a **24-hour** advanced notice for **weekdays** and for **Saturday** cancellations **one week notice**. For your convenience, we will call to confirm your appointment one day prior to your appointment. If you cancel on the same day as your appointment, you will be considered a **NO SHOW** without penalty. The second **NO SHOW** may result in a **$35.00 charge to your account**.

Initial_____ Minors: The parent or guardian accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. **We are able to take the payment over the phone with a credit card.**

I have read, understand, and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current personal and insurance information. I authorize Smile Image Dentists to file any necessary insurance claims on my behalf.

Patient Name: _____ DOB: _____

Responsible Person's Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgment**

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

(Please Print Name)

_____

(Signature)

_____

(Date)

Submit Form

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ **Individual refuse to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)