New Patient Form

Smyrna Smiles FAMILY DENTISTRY

First Name _____ Last Name _____ Middle initial _____ Preferred Name _____

Date of Birth _____ Gender: ◯ Male ◯ Female

Address _____ City _____ State _____ Zip _____

Best phone number to contact you: Mobile_____ Phone _____

Social security No. _____ Email _____

I would like to receive correspondences via Email: ◯ Yes ◯ No Text: ◯ Yes ◯ No

Whom may we thank for Referring you to our office? _____

Employer Name _____ Occupation _____

Insurance Information

Primary Insurance	**Secondary Insurance**
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child	Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

*** Please present your insurance card and driver license to be photocopied for our records ***

Responsible Party Information (if someone other than yourself)

First Name _____ Last Name _____ Middle initial _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Contact: Mobile_____ Phone _____ Email _____

Emergency contact name _____ **Phone** _____

Dental history

Former dentist name _____ City _____ State _____

Date of your last visit _____

Please tell us your chief dental complaints _____

_____

Consent

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my *(or my child's)* health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Patient Signature _____Date _____

Medical History Form

Smyrna Smiles FAMILY DENTISTRY

Patient Name _____ DOB _____

Are you under a physician's care now? ◯ Yes ◯ No If Yes, please explain: _____

Have you ever been hospitalized or had a major operation within the past 5 years? ◯ Yes ◯ No If yes, please explain:

_____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, Didronel or medication containing Bisphosphonates? ◯ Yes ◯ No

If yes, how long have you taken? _____

Are you currently taking Blood Thinner/Anticoagulants? ◯ Yes ◯ No

Do you require antibiotics before certain dental procedures due to having history of infective endocarditis, prosthetic cardias valves, and prosthetic joints? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Have you been tested for HIV (AIDS)? ◯ Yes ◯ No

If yes, tested ◯ Positive ◯ Negative

Do you use controlled substances/Alcohol? ◯ Yes ◯ No

Have you used any within the last 24 hrs.? ◯ Yes ◯ No

Have you ever been tested for Substance Abuse? ◯ Yes ◯ No

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Local Anesthetics ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa Drugs

◯ Other, Please Explain: _____

Women Patients Only

Are you currently pregnant? ◯ Yes ◯ No Estimated Delivery Date: _____

Are you taking any birth control prescription? ◯ Yes ◯ No Are you Nursing? ◯ Yes ◯ No

PLEASE CHECK ANY CONDITION THAT APPLY TO YOU BELOW

AIDS/HIV Positive	◯ YES	Cortisone Medicine	◯ YES	High Blood Pressure	◯ YES	Sinus Problems	◯ YES
Alzheimer's Disease	◯ YES	Diabetes	◯ YES	High Cholesterol	◯ YES	Stroke	◯ YES
Anaphylaxis	◯ YES	Drug Addiction	◯ YES	Hives or Rash	◯ YES	Thyroid Disease	◯ YES
Anemia	◯ YES	Easily Winded	◯ YES	Hypoglycemia	◯ YES	Tuberculosis	◯ YES
Angina	◯ YES	Emphysema	◯ YES	Irregular Heartbeat	◯ YES	Ulcers	◯ YES
Arthritis/Gout	◯ YES	Epilepsy	◯ YES	Kidney Problems	◯ YES	Visually Impaired	◯ YES
Artificial Heart Valve	◯ YES	Excessive Bleeding	◯ YES	Liver Disease	◯ YES	Low Blood Pressure	◯ YES
Artificial Joint/Pins	◯ YES	Fainting	◯ YES	Herpes	◯ YES	Shingles	◯ YES
Asthma	◯ YES	Frequent Cough	◯ YES	Lung Disease	◯ YES	Seizure	◯ YES
Blood Disease	◯ YES	Genital Herpes	◯ YES	Mitral Valve Prolapse	◯ YES	Convulsions	◯ YES
Breathing Problem	◯ YES	Hay Fever	◯ YES	Hepatitis B or C	◯ YES	Osteoporosis	◯ YES
Bruise Easily	◯ YES	Heart Attack	◯ YES	Pain in Jaw Joints	◯ YES	Rheumatic Fever	◯ YES
Cancer	◯ YES	Heart Murmur	◯ YES	Parathyroid Disease	◯ YES	Psychiatric Care	◯ YES
Chemotherapy	◯ YES	Heart Pacemaker	◯ YES	Hepatitis A	◯ YES	Radiation Treatment	◯ YES
Chest Pain	◯ YES	Congenital Heart Disorder	◯ YES	Heart Trouble	◯ YES	Cold Sore/Fever Blister	◯ YES

If yes to any condition above, please explain: _____

_____

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:

_____

* Please list any current medications and the correlating diagnosis: _____

_____

Physician name: _____

Address: _____

Phone: _____

Date of your last visit: _____

Pharmacy name: _____

Address: _____

Phone: _____

I affirm that the above information I have given is correct to the best of my knowledge. It is my responsibility to inform this office of changes in the patient's medical status.

Patient Signature _____ Date _____

Smyrna Smiles
FAMILY DENTISTRY

FINANCIAL POLICIES

Welcome to Smyrna Smiles Family Dentistry. We hope to make your appointment as pleasant as possible and ease your potential financial burden as much as possible. Please review our insurance and payment policies below to help you understand your financial responsibilities.

Patients without dental benefits: Full payment is due at the time service is rendered.

Patients with dental benefits: All deductible and the **ESTIMATED** patient portion are due at the time of service.

WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT

INSURANCE CLAIMS: Smyrna Smiles provides insurance company billing as a courtesy to our patients. Please be advised that services are rendered and charged to you, not your insurance company. Please understand that the contract is between you and the insurance company and payment for services is your responsibility. If at the end of 45 days, your insurance company has not paid, you are responsible for the entire balance. Our office will not enter into dispute with your insurance company over your claim. Upon request, we will supply you with a copy of the claim.

The claims we submit to insurance companies indicate that you have assigned those benefits to Smyrna Smiles Family Dentistry. However, if you are paid by the insurance company instead of Smyrna Smiles Family Dentistry, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You as a patient are always responsible for any charges that are not covered by your insurance.

DELINQUENT PAYMENT: It is our policy to charge finance fees at **1.5%** for outstanding patient balances after the balance has been outstanding **45 days.** All payments returned due to non-sufficient funds will be subject to a fee of **$35.00.** In addition, you are also responsible to pay any court costs and attorney fees necessary to collect unsecured debts.

By signing below, I acknowledge my responsibility to pay for the services received from Smyrna Smiles Family Dentistry in accordance with the office fees and terms. My responsibility is not modified by whether any third party (insurances) pays for all or part of the charge.

Signature: _____ Print Name: _____ Date: _____

Smyrna Smiles
FAMILY DENTISTRY

APPOINTMENT POLICY

We are honored that your family has entrusted Smyrna Smiles Family Dentistry for your dental care. We strive to give each patient the individual attention they deserve. Therefore, we ask that you arrive on time for your appointment. If you arrive 15 minutes late to your appointment, we may need to reschedule your appointment. If we are able to see you, we cannot guarantee that all treatment will be completed. If a second appointment is missed, the patient may be dismissed from our practice, or required to make non-refundable deposit before scheduling another appointment.

CANCELLATION POLICY: We understand that a situation may arise that could force you to postpone your visit. Please understand that such changes affect not only the doctor, but other patients as well. We require 48 hrs. notice for any schedule changes. There will be a **$50.00** charge for missed appointment and those cancelled with less than 48 hrs. notice. This fee cannot be charged to your insurance company. You will be responsible for payment of the broken appointment fee. Broken appointment fee will need to be paid before scheduling an appointment. We will call/email/text you 2 business days prior to your appointment to confirm. Appointments not confirmed will automatically be cancelled. We may also call you the day before your appointment to remind you of your appointment.

I acknowledge the appointment agreement above.

Signature: _____ Print Name: _____ Date: _____

ELECTRONIC COMMUNICATION POLICY: We'd like to keep in touch regarding your upcoming appointments, treatment plan, and treatment status. By providing your email address, phone number, and mailing address, you are giving Smyrna Smiles permission to contact you through one or all of these communication methods. Note that email and text messaging is not secure and there is a risk that they could be read by a third party. By sharing your email or mobile number with us you are acknowledging that you are aware of this risk and agree to receive this type of communication.

I consent to receiving electronic communications, including email and text messages regarding treatment, payment, and health care operations in accordance with this document.

Signature: _____ Print Name: _____ Date: _____

HIPPA Privacy Practices Acknowledgment

Patient Name _____DOB _____

Acknowledgment of Receipt of H.I.P.A.A., the Health Insurance Portability Act Notice of Privacy Practices

Notice of Privacy Practices: Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. A copy of our Notice is available upon request. We encourage you to read our Notice carefully and completely before signing this Acknowledgment.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I, _____ have had full opportunity to read and consider the contents of this Acknowledgment and the Notice of Privacy Practices. I understand that, by signing this Acknowledgment, I am giving my authorization to your use and disclosure of my protected health information in accordance with the Notice.

Patient Signature _____Date _____