AFFORDABLE SMILES

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Dental Registration and History

AFFORDABLE SMILES

Health History

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head		
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Consent for Dental Treatment and Acknowledgement of Receipt of Information

State Law requires us to obtain your consent for dental treatment. Please do not hesitate to ask us to explain anything to you that you may not understand before treatment is rendered. This is a general consent for treatment form. All of your options and a thorough explanation of the procedures will be given to you.

I understand dentistry is not an exact science and complications may occur despite our best efforts. There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental care being rendered. Some of these risks/complications are, but are not limited to, the following:

- Sensitivity to temperature (hot/cold)
- Damage, fracture or possible loss of the tooth/teeth being treated as well as adjacent teeth and bone
- Failure of wound to heal
- Injuries to adjacent teeth and/or soft tissue
- Paresthesia or numbness of: tongue, and/or mouth, and/or face
- Fracture of mandible (upper jaw) or maxilla (lower jaw)
- Opening between mouth and sinus or mouth and nose
- Slough (unanticipated loss of hard and/or soft tissue)
- Swallowing and/or aspiration of prosthesis and other objects
- Trismus (jaw pain or difficulty opening mouth)
- Additional surgery, hospitalization and/or further treatment may be required in the event of any complication(s)
- Burns from chemical agents used in treatment or dental treatments
- Loss of or damage to the ability to taste, speak, hear and/or see
- Breakage or root(s) and retained root fragments
- Damage to or possible loss of filings or other dental work
- Change in bite
- Incomplete removal of tooth
- Loss of tooth/teeth or loss of bone
- Dry socket
- Injury to adjacent structures
- Instrument breakage
- Allergic reaction to drugs
- Bacterial Endocarditis
- Failure or treatment to accomplish its purpose
- TMJ Dysfunction or worsening of TMJ condition
- Injury from airborne particles or instruments
- Infection
- Bleeding
- Tooth or fragment in maxiallary sinus

State Law also requires that I specifically advise you, although rarely occurring, the dental treatment or anesthetic may result in: Paraplegia (paralysis of both legs); Quadriplegia (paralysis of both arms and legs); Loss or loss of function of an organ(s) or limb(s); Brain Damage; or Death.

Acknowledgment

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction. I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid until revoked by me in writing.

_____ _____

Signature of Patient or Guardian **Date**

AFFORDABLE SMILES

FINANCIAL ARRANGEMENT POLICY

Payment for services is due in full at the time services are rendered unless prior arrangements are made with our office. Any account balance 90 days old or greater may be subject to interest charges, delinquent billing fees, collection fees, attorney fees, and/or court cost. If your scheduled appointment time for treatment is 1 ½ hours or greater, a 50% deposit towards your portion due is required at the time the appointment is scheduled. We accept cash, credit card, and check payment. Should a check return as Non-Sufficient Fund, our office will bill you for the original amount and an additional $25 bank fee will be added.

_____ _____

Signature of patient, parent, or responsible party **Date**

SCHEDULING POLICY

To offer quality care to all of our patients, you are seen by appointment. By doing this, we may be ready and able to see you in a timely manner. We strive for prompt service so that you will not be left waiting. Therefore, we ask that you ARRIVE ON TIME for your appointment. Due to the volume of patients needing our care we also ask, should a change in your schedule occur you call to reschedule at least 24 HOURS prior to your appointment. If proper notice is not given, this will result in **a $50.00 MISSED APPOINTMENT FEE** for each hour scheduled. As a courtesy, we will call you prior to your appointment as a reminder. We thank you for your cooperation.

_____ _____

Signature of patient, parent, or responsible party **Date**

Insurance Notice to Our Patients

You have indicated to us that you have dental insurance. As a courtesy to you, we will submit your services and wait for payment. You are responsible for monitoring the use of your benefits and remaining within your maximum covered benefit during each year of coverage.

However, when we go over treatment plans with you, this is only an estimate from the percentages given to us by your insurance company. The deductible and estimated percentage that your insurance company does not cover is to be paid upon the date of service.

When you pay your estimated portion, this does not always mean that you have paid your final payment towards these services. If your insurance company does not pay the entire estimated amount, you are left responsible to pay any remaining balance. Please note that our fees are not based on any insurance schedules, and may be above insurance allowances. We do not accept downgraded fees or insurance code changes.

By signing this form, I understand these terms.

_____ _____

Patient Name Date

_____ _____

Signature of Patient, Parent, or Responsible Party Date

NOTICE OF PRIVACY PRACTICES

I understand that my healthcare information concerning my diagnosis, treatment, payment, and insurance will be disclosed when necessary for filing insurance, and in communication with other health professionals in the course of my treatment or their offices. Limited information will also be disclosed to business supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support, billing personnel, answering services, and consultants. These businesses are restricted in the use and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that family member or person.

I understand that my files are stored on shelves in the business office. Only staff and janitorial personnel may have access to this office during non business hours. I understand that this office will make every effort to keep you information secure and correct any violation of my privacy if this should occur.

I understand that I have the right to access, copy, or inspect and correct my healthcare information, the right to restrict disclosures and obtain an accounting of disclosures. I have the right to voice my concern about privacy to the practice and/or the Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by this office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure. (A minimal fee will be charged to me for copies of records that I request)

I understand that I will receive communication in the form of phone calls and/or postcards to remind me of an existing appointment. I may receive mail containing financial information, such as ledgers or bills. Communication may also be sent to me in the forms of fax or e-mails or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home or work voice mail.

I have read and understand this office policy. I understand that by signing this agreement, I give my permission for the use and disclosure of my personal and health information in order to carry out treatment, payment activities, insurance claims, and health care operations. This office retains the right to revise the privacy policy.

_____ _____

Patient Signature **Date**

Designation of Personal Representative

Please use this form to designate a personal representative to act on the behalf of the patient below, in making health care-related decisions, and to have unlimited access to the patient's information. The patient named below is signing this designation and consenting to the release of information. If the patient is a minor, a parent or legal guardian must sign. If the patient is unable to sign for any other reason, a legal representative must sign the designation and submit documentation to verify the authority to sign.

Patient's Name _____ Date of Birth _____
Address _____
Home Ph ( ) _____ Work Ph ( ) _____ Cell Ph ( ) _____
I hereby designate the following individual(s) as my personal representative:
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Please read each of the following statements carefully before signing this document.

● I understand that this designation will not expire unless I indicate an expiration date or I revoke it.
Date to expire: _____ (if indicated)

● I understand that this designation is voluntary and being made at my request.

● I understand that the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual that receives the information.

● I understand that I may revoke this Designation of Personal Representative at any time by sending a written notification to Affordable Smiles, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that my health plan has already used or disclosed, relying on this designation. I may receive a copy of this designation and agree that a photocopy is as valid as the original.

Print Name _____ Date _____

Signature _____ Relationship to patient _____

Photography Release

I, _____, hereby authorize Dr. _____or his/her assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.

I understand that the x-rays, photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature _____

Date _____