Smiles for Life Dental Care

PATIENT INFORMATION FORM

Today's Date:					
PATIENT INFORMATION					
Patient's last name: First:		Middle: Prefix:	Marital status: Single / Mar / Div / Sep / Widow		
E-mail address:	Preferred Contact Method: (Hm Phone, Wk Phone, Wireless Ph)	Preferred name (Nickname):	Birth date: (MM/DD/YYYY)	Age:	Sex: (M/F)
Address:					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.:		
Chose clinic because/referred to clinic by:					
Other family members seen here:					
INSURANCE INFORMATION					
(Please give your insurance card and driver's license to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here? Yes No		Is this patient covered by insurance?	Yes No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):		Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Smiles for Life Dental Care or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Smiles for Life Dental Care
PATIENT INFORMATION FORM
(Please Print)

Patient's Last Name: First: Middle:

MEDICAL HISTORY

Physician: _____
Phone Number: _____

Yes	No	
☐	☐	Is patient in good health?
☐	☐	Are immunizations up to date?
☐	☐	Is patient under a physician's care? For what? _____
☐	☐	Does patient have any history of major illness? What? _____
☐	☐	Has patient ever been hospitalized? For what? _____
☐	☐	Is patient receiving any medication/drugs presently? What? _____
☐	☐	**Does patient have any allergies or drug sensitivities? List:** _____
☐	☐	Does patient have tendency to ☐colds, ☐sore throat, ☐ear infections, ☐sinus congestion, ☐breathing problems?
☐	☐	Have tonsils and/or adenoids been removed? What age? _____

Check/Circle any of the following conditions for which the patient has been treated:

☐ Aids	☐ Epilepsy/Seizures	☐ Liver/Kidney Disease
☐ Arthritis	☐ Emotional Problems	☐ Nutritional Problems
☐ Asthma	☐ Endocrine Problems	☐ Prolonged Bleeding
☐ Blood Problems	☐ Fainting/Dizziness	☐ Rheumatic Fever
☐ Bone Disorders	☐ Heart Trouble/High Blood Pressure	☐ Speech, Hearing Problems
☐ Cerebral Palsy	☐ Hepatitis	☐ Tonsillitis
☐ Diabetes	☐ HIV Positive	☐ Tuberculosis

Women: Are you: **Pregnant?** Yes, ____months NO **Nursing?** Yes NO **Taking birth control pills?** Yes NO

Any other significant medical, psychological, or disability problems, please describe? _____

_____

DENTAL HISTORY

Yes	No	
☐	☐	Have there been any injuries to the face, mouth or teeth? _____
☐	☐	Has patient ever sucked thumb or fingers? Until what age? _____
☐	☐	Does the patient have any speech problems? _____
☐	☐	Is patient a mouth breather? ☐ While awake? ☐ While asleep? _____
☐	☐	Does patient have noticeable problems in chewing or swallowing? _____
☐	☐	Any clicking, popping, or discomfort upon opening or closing mouth? _____
☐	☐	Does the patient see the dentist regularly? Date last seen? _____
☐	☐	Has any previous dental treatment occurred? If yes, what kind? _____
☐	☐	Were there any problems with previous dental treatment? If yes, what kind? _____
☐	☐	Is your drinking water fluoridated? _____
☐	☐	Are supplemental fluorides (e.g. rinse, gel) used? What kind? _____

How often are teeth brushed? _____ Flossed? _____ By Whom? _____

What are your concerns for today's visit? Please list here: _____

_____

I acknowledge that this information is correct and hereby authorize a comprehensive examination including necessary radiographs and other indicated diagnostic procedures to accomplish these services.

_____ _____ _____

Reviewer Signature of Legal Consent Date

Smiles for Life Dental Care
5745 Old Winder Hwy, Ste. E
Braselton, GA 30517
Office (678) 866-8770 Fax (678) 866-8771

Acknowledgment of Receipt of Notice of Privacy Practices

Patient name:_____ Date of birth:_____

I have received either a paper or an electronic copy of the Notice of Privacy Practices for Smiles for Life Dental Care. I understand that I am entitled to receive a paper copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

X_____ Date signed:_____

Signature of patient's personal representative

Representative's relationship to patient:_____

Representative's name:_____ Phone:_____

Representative's address:_____

For office use only:

Please complete the following only if the acknowledgment section above has not been signed by the patient's personal representative: We made a good faith effort to obtain a written Acknowledgment of Receipt of Notice of Privacy Practices, but an acknowledgment could not be obtained because (*please check one or more as appropriate*):

- ☐ The patient's personal representative refused to sign.
- ☐ A communication barrier prevented us from obtaining an acknowledgment.
- ☐ An emergency situation prevented us from obtaining an acknowledgment.
- ☐ Other (please explain)_____

_____

_____

_____

_____

_____

_____

Completed by:_____ Position:_____

Staff member's initials:_____ Date completed:_____

Smiles for Life Dental Care
5745 Old Winder Hwy, Ste. E
Braselton, GA 30517
Financial Agreement

Welcome to our practice!

Your dental health is of the utmost importance to us. Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy. We look forward to a long-term, professional relationship with you!

Payment Responsibilities

All accounts are due and payable at the time of service. If a procedure requires multiple appointments, payment is required in full at the first appointment. The patient is responsible for the estimated non-covered portion, procedures and/or deductibles at the time of the service, or the patient can sign a credit card authorization to bill their credit card after insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance. Parents not accompanying their children to an appointment must make prior arrangements for payment (cash or credit card authorization). Parents accompanying their children are financially responsible for payment.

Payment options

We accept cash, checks, and credit card (Visa, MasterCard, Discover, and American Express).

Insurance Claims

If we are filing an insurance claim for you, you will need to pay us at the time of treatment the insurance deductible required by your plan and any amount that we estimate will not be covered by your insurance company. We try to get accurate information about your insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage and benefits. This is important for you to understand because you are responsible for all treatment charges, whether or not your insurance company provides any benefits. Any remaining balance that is not paid by the insurance company will be your responsibility and you will be billed for this amount.

Broken or Cancelled Appointments

We reserve instruments, chairs, and personnel exclusively for your appointment. If you need to cancel an appointment, please notify our office at least 48 hours in advance for all appointments. After two broken or cancelled appointments, our office will charge $50.00 for each cancelled or no-show appointment if you do not give us the requested advance notice. If you experience an emergency and it makes it impossible for you to give us 48 hours notice, please notify us as soon as possible so we can discuss this with you. The charges will be regardless of the reason as we do not feel it is appropriate for us to judge whether or not a reason is good or valid.

Release of Information:

I authorize Smiles for Life Dental Care to release information as may be required to insurance companies for processing of my and/or my dependent(s) claims and to use and disclose health information about my treatment and services to bill and collect from me, my insurance company or a third party payer.

I understand and agree to these financial terms.

Signature: _____ Date: _____

Patient Name (Please print): _____

Parent/Guardian Name (Please print): _____