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Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

E-mail: _____ ☐ I would like to receive email correspondences

Patient is: ☐ Responsible Party ☐ Policy Holder

How did you hear about us: _____

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○ Full Time ○ Part Time

Preferred Pharmacy: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Member ID: _____ Medicaid ID: _____

Insured SS #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Group #: _____

Insurance Address: _____

City, State, Zip: _____

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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	
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	
Are you on a special diet?	○ Yes	● No	
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	
Do you need to pre-medicate?	○ Yes	○ No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? (*Circle*) ○ Yes ○ No Taking oral contraceptives?(*Circle*) ○ Yes ○ No Nursing?(*Circle*) ○ Yes ○ No

Are you allergic to any of the following? (*Circle*)

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following? (*Circle*)

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

Have you ever had any serious illness not listed above?(*Circle*) ○ Yes ○ No If yes, please explain: _____

_____

_____

List all medications you are taking: _____

_____

_____

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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Dental Treatment Consent Form (English)

Patient Name: _____ BP: _____
Birthdate: _____ Pulse: _____

Please read and initial the items checked below

_____ 1. WORK TO BE DONE
I understand that I am having the following work done: X-Rays _____ Prophy _____ Sealants _____
Full Mouth Debrivment _____ Scaling & Root Planning _____ Fillings _____ Local Anesthesia_____ Other _____

_____ 2. DRUGS AND MEDICATION S
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

_____ 3. CHANGES IN TREATMENT PLA N
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

_____ 4. REMOVAL OF TEE T H
Alternative to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment the cost of which is my responsibility.

_____ 5. CROWN, BRIDGES, AND CAPS
I authorize the Dentist to perform crown or bridge procedures on the following teeth _____. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

_____ 6. DENTURES, COMPLETE, OR PARTI AL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the ‘’teeth in wax’’ try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

_____ 7.ENDODONIC TREATMENT (ROOT CAN A L)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root. Which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment.

_____ 8. PERIODONTAL LOSS (TISSUE & BO NE)
I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that dental practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding my treatment, and all questions have been answered to my satisfaction.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

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Appointment Cancellation and No-Show Policy

We do require a **24 hour** notice for any changes or cancellations to your appointment. This allows us the time in our schedule to be filled by another patient who may have been waiting for this appointment time.

A fee will be charged to your account for not honoring this policy. There is a **$25 charge** for each 1/2 hour of scheduled appointment time missed. For example, if you had an hour appointment scheduled, the charge is $50.

We reserve time in our schedule for you in order to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment.

Thank you for your understanding and consideration.

Medicaid/CHIP Patients:

Our office is bound to notify MCNA & DENTAQUEST of any cancelled appointments or no shows. If you cancel or do not attend your appointment, our system notifies them automatically.

Patient/Legal Guardian Signature: _____ Date: _____

If you may have any questions or concerns, please feel free to contact our business manager.

Thank you,

Management

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ACKNOWLEDGEMENT OF RECEIPT OF
HIPPA NOTICE OF PRIVACY PRACTICES
(''Acknowledgement")

I acknowledge that I have received a copy of this Dental Practices's **HIPPA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (*check one*):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other: _____

_____ _____
Staff Member Signature Date

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Financial Policy Consent Form

We welcome you and your family to Smilepoint Dental. We look forward to providing you with top- notch quality dental care at affordable prices. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your treatment as much as possible.

You need to be aware that:

• We will always do our best to help you to maximize your benefits.

• Although we file claims for your courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.

• Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits.

• Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

• It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

• Our staff is trained to help you with questions you may have relating to how your claim was filed, or regarding any additional information your carrier may need to process your claim. Please, ask if you have any questions.

• As a courtesy to all our insured patients, we will file your dental insurance claim forms. In special circumstances, a particular insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly.

• Your claim will be filed immediately, and benefits are expected to be paid within 30-45 days .The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become ''self-pay'' and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay for whatever reason.

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Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail. I understand and accept the financial and dental insurance policies listed above and have had any questions answered to my satisfaction.

I agree to pay for all treatment in a timely fashion as described.

Refund Policy:
All payments collected on date of service may be refunded same day. Refunds request after date of service will be processed within 15 days of refund submission form, Please note ALL PENDING INSURANCE CLAIMS must be paid by your insurance company before a refund may be made.

[For patients with dental insurance who would prefer their insurance company to send payment to the office]

I _____ hereby authorize my insurance benefits to be paid directly to Smilepoint Dental. I realize that I am responsible to pay for any deductible amount(s), my co- insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original.

X _____ Patient/Legal Guardian _____ Date

X _____ Staff Initials