Smile Wellness

PATIENT REGISTRATION FORM

Patient Last Name: _____ **First:** _____ **Initial:** _____

How do you wish to be addressed? _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Telephone *(Home):* _____ *(Work):* _____ *(Mobile):* _____

Email: _____ Social Security Number: _____

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 ☐ Other	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
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 to be photocopied for our records.

Responsible Party *(If minor)*

Last Name: _____ First: _____ Initial: _____

Address *(If different):* _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Telephone *(Home):* _____ *(Work):* _____ *(Mobile):* _____

Email: _____

Emergency Contact

Last Name: _____ First: _____ Initial: _____

Telephone *(* ☐ *Mobile* ☐ *Work* ☐ *Home):* _____

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.

Signature: _____ Date: _____

(Responsible Party, if under 18)

HEALTH HISTORY FORM

Smile Wellness

PLEASE COMPLETE ALL INFORMATION - THANK YOU

Last Name: _____ **First Name:** _____ **Middle Initial:** ____ **Date Of Birth:** _____

Dental History

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:

- ☐ Bad breath
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Dry mouth
- ☐ Extra permanent teeth
- ☐ Food collection between teeth
- ☐ Grind teeth
- ☐ Clench teeth
- ☐ Growths or sore spots in your mouth
- ☐ Gums swollen, tender or bleeding
- ☐ Head, neck, TMJ/jaw pain, or aches
- ☐ Loose teeth or broken fillings
- ☐ Missing permanent teeth
- ☐ Mouth breathing
- ☐ Nitrous oxide
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Sensitivity to pressure or irritants *(cold, heat, sweets)*
- ☐ Smokeless tobacco
- ☐ Do you currently smoke or have you smoked? Check applicable options below:
  - ☐ Occasionally/Light ☐ Average
  - ☐ Heavy ☐ Ex-Smoker
- ☐ Do you have a history of sleep apnea or snoring?
- ☐ Any injuries to face, mouth or teeth? If Yes, please explain: _____
- ☐ Have you ever had trouble from previous dental care? If Yes, please explain: _____
- ☐ Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? If Yes, please explain: _____
- ☐ How often do you floss? _____
- ☐ How often do you brush? _____
- ☐ Do you premedicate prior to dental treatment?

Additional questions for patients under 14:

- ☐ ADHD/ADD
- ☐ Immunizations are current
- ☐ Frequent bottle use/Sleeps with bottle at night
- ☐ Frequent sores on lips or mouth
- ☐ Nail biting
- ☐ Thumb, finger, or lip sucking or biting habit(s)
- ☐ Local anesthetic has been administered previously
- ☐ Reached puberty

Medical History

Physician's name _____ Physician's phone # _____ Date of last visit _____

Please check if you have/had:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial joints
- ☐ Birth control
- ☐ Blood disease
- ☐ Bone disorders
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Clotting disorders, and/or prolonged bleeding
- ☐ Cortisone treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Endocrine problems
- ☐ Epilepsy/Seizures
- ☐ Fainting or vertigo
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Heart, artificial valves
- ☐ Heart, mitral valve prolapse
- ☐ Hepatitis *(select type from below)*
  - ☐ A ☐ B ☐ C
- ☐ Herpes
- ☐ High blood pressure
- ☐ Immune deficiency *(including HIV/AIDS)*
- ☐ Jaundice/Other liver problem
- ☐ Kidney disease
- ☐ Low blood pressure
- ☐ Nursing
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Pregnant, due date: _____
- ☐ Radiation treatments
- ☐ Respiratory disease
- ☐ Rheumatic fever/disease
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Sleep study/CPAP
- ☐ Sickle cell anemia
- ☐ Skin rash
- ☐ STD/STI
- ☐ Stroke
- ☐ Swelling of feet/ankles/joints
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tonsils removed? Date: _____
- ☐ Tuberculosis *(TB)*
- ☐ Tumor or growth on head/neck
- ☐ Ulcer
- ☐ Weight loss, unexplained
- ☐ Have you had any blood transfusions? Approximate dates: _____
- ☐ Do you consume alcoholic beverages?
- ☐ Are you currently under the care of a Physician?
- ☐ Do you have a history of substance abuse?
- ☐ Have you ever had surgery? Approximate date of last surgery: _____
- ☐ Are you allergic or sensitive to latex?
- ☐ Do you have any allergies? *(Select one or more)*:
  - ☐ Hay fever, sinusitis
  - ☐ Nickel
  - ☐ Nuts
  - ☐ Other, please specify: _____
- ☐ Do you have Asthma?
  - ☐ Required hospitalization
  - ☐ Used steroids
  - ☐ Date of last episode: _____
- ☐ Are you currently taking any medications? If yes, please list: _____
- ☐ Any other medical conditions or concerns? _____

MedHX Notes (OFFICE USE ONLY)

Authorization and Release

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Smile Wellness

Financial Policy

Patient Name: _____ **Date:** _____

Smile Wellness is committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- **SMILE WELLNESS PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

Adult Patients

Adult patients are responsible for full payment at time of service.

Minors Accompanied By An Adult

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

Unaccompanied Minors

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

Insurance

Smile Wellness provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by staff regarding his/her remaining benefit in any such benefit period

The claims we submit to insurance companies indicate that you have assigned those benefits to Smile Wellness. However, if you are paid by the insurance company instead of Smile Wellness, 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.

Medicare/ Medicaid/ Champus/ Worker's Compensation

If you are covered by Medicare, Medicaid, Champus, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the Smile Wellness office on the date of service.

Delinquent Payments

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

Missed Appointments

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of **$50.00** per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: _____ **Date:** _____