CREATING SMILES DENTAL

PATIENT INFORMATION

Name: _____ Sex: __ Email:_____

Cell phone:_____ Home phone: _____ Marital status: Single Married Divorced Widowed

Address:_____City _____State_____ Zip_____

Birthday: _____ Social Security # _____ Driver's license # _____

Occupation:_____Employer:_____ Work phone:_____

In case of emergency, contact: _____ Phone:_____ Relationship:_____

Responsible for this account: _____ Phone:_____ Relationship:_____

Date of birth: _____ Social Security # _____ Driver's license # _____

How did you hear about us? _____

INSURANCE INFORMATION

Insurance Co:_____Group #:_____ Subscriber #:_____

Name of Insured:_____Relationship with Patient:_____

Date of birth: _____ Social Security # _____ Date employed:_____

Employer:_____ Work phone: _____

Employer address:_____City:_____State_____Zip _____

Secondary Insurance Co:_____Group #:_____ Subscriber #:_____

CONSENT TO TREATMENT/ AGREEMENT TO PAY

I hereby authorize the performance of dental services upon the above named patient. I also authorize any diagnostic X-ray and photographs deemed necessary by the doctor to enable complete diagnosis and treatment.

I agree to pay for all services rendered. I understand that I may be charge 1.5% per month finance charge if my balance goes beyond 90 days. I may also be charged for all legal fees and costs incurred if my balance goes to collection. In order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you. I understand that all fees incurred for dental treatment are my responsibility, regardless of any insurance I may have. I assign dental benefit payments to be paid directly to Cindy Brayer DMD PA from my insurance company. In the event that my insurance does not provide benefits or provides reduced benefit, I will be responsible to pay the agreed upon fee schedule.

Signature of Patient_____Date_____

Signature of Parent or Guardian (if minor):_____Date_____

PATIENT'S DENTAL HISTORY

Reason for today's visit _____

Do you have dental pain/ sensitivity?_____ Where?_____When?_____

Former dentist _____Last visit:_____Date of last X-rays_____Last cleaning_____

Reasons for changing dentist_____

How often do you brush?_____How often do you floss?_____

Do you feel nervous about dental treatment? _____If so, what is your biggest concern?_____

Check if you have any of the following:

- o Bad breathe
- o Bleeding / Swollen gum
- o Clenching/ Grinding teeth
- o Clicking/ Popping jaw
- o Loose/ Broken teeth
- o Sores/ growths in your mouth
- o Acid reflux

Please answer the questions below:

Yes No I want to keep my teeth

Yes No I have had a deep cleaning/ gum surgery in the past

Yes No I have had braces in the past

Yes No I have had facial/ Jaw injury

Yes No I want my teeth whiter, straighter

Yes No I want to have denture

PATIENT'S MEDICAL HISTORY

Physician's Name:_____Phone:_____Last visit:_____

Check if you have any of the following:

- o Anemia
- o Arthritis
- o Asthma
- o Back problem
- o Blood disease
- o Chemical dependence
- o Diabetes
- o Epilepsy/ Seizures
- o Fainting spells
- o Glaucoma
- o Heart disease
- o Hepatitis, type____
- o Herpes
- o High Blood Pressure
- o HIV/ AIDS
- o Immune suppressed
- o TMJ
- o Kidney disease
- o Liver disease
- o Mitral valve prolapse
- o Nervous disorder
- o Pacemaker
- o Prolong bleeding
- o Respiratory disease
- o Rheumatic fever
- o Scarlet fever
- o Sinus problem
- o Stroke
- o Swelling ankles
- o Thyroid problems
- o Tuberculosis
- o Tumor/ Malignancies
- o Tonsillitis
- o Ulcer
- o Venereal disease
- o Other

Yes No I smoke or use chewing tobacco. If yes, how many per day?_____How many years?_____

Yes No Are you pregnant/ Nursing? If yes, how many month?_____

Yes No I must take premedication Antibiotic prior to dental treatment. Name of medication_____

Yes No I have taken Biphosphonates for osteoporosis. If yes, How many years?_____Name of medication___

Yes No I have had major surgery. If yes, what type?_____When?_____

Yes No I have cancer. If yes, what type?_____When?_____What treatment?_____

Yes No I am on blood thinner medication. If yes, name of medication_____

Yes No I have prosthetic joints (knee, hip, other)_____When?_____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

ALLERGIES

- o Aspirin/ Ibuprofen
- o Codeine
- o Latex
- o Local anesthetics
- o Other (list...
- o Metal
- o Penicillin
- o Tetracycline
- o Plastic/ Acrylic
- o Sulfa drugs

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

_____

Signature of patient/ Parent or guardian (if minor)

Medical health reviewed by:

Doctor's Signature:_____Date:_____

CREATINGSMILES DENTAL/HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___

_____
Signature of Privacy Officer

HIPAA made EASY™
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Creating Smiles Dental

SCHEDULING & FINANCIAL POLICY

SCHEDULING POLICY

When we reserve time for your dental appointment, we are reserving the doctor/assistant or hygienist's time for you as well as saving the room, ordering supplies and equipment necessary to perform your treatment on your scheduled visit. Therefore, our scheduling policy is as follows:

- We require a minimum deposit of one-third (1/3) down payment of the treatment's fee to reserve an appointment.
- Patients who fully prepay for their dental treatment at the time of scheduling will receive a 5% prepayment discount.
- We require at least 24 hours' notice to cancel an appointment, unless there is a mutually agreed upon emergency.
- When you miss two (2) appointments with less than 24 hours' notice, you will be charged a $75 cancellation fee and must prepay for all future treatment on the day of scheduling.
- If you miss three (3) appointments with less than 24 hours' notice in a 365 day period, you may be dismissed from our practice as a patient of record.

FINANCIAL POLICY

Payment for dental services is due at the time dental treatment is rendered.

For your convenience, we accept CASH, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER and third party financing, like CARE CREDIT and SPRINGSTONE.

Account balances that are not fully paid within 30 days of treatment are considered PAST DUE, unless other arrangements are made in advance, and may be subject to collections. Patients may also be charged all legal fees and costs incurred if the balance goes to collections.

If a balance is not paid within 60 days, a patient may be charged a 1.5% per month finance charge (not to exceed 18% charge a year), which will be added to their account until the balance is paid in full.

All dental fees incurred by the patient are completely the patient's responsibility, regardless of any insurance policy they may have. Returned checks will be assessed a $30 Returned Check Fee.

"My signature verifies that I have read, understand and am willing to comply with the Scheduling and Financial Policies, as described above."

Print Patient's Name	Signature of Patient/Guardian	Date
Print Witness' Name	Signature of Witness	Date

Creating Smiles Dental
DENTAL INSURANCE POLICY

Dental insurance is meant to be a financial aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. In reality, most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage, or the type of contract your employer has set up with the insurance company. **You must understand your insurance benefits.** If you have any questions with your insurance benefits, please call your insurance company directly to clarify your policy. Our primary goal is not to allow the cost of treatment to prevent you obtaining the quality dental care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance affordable for your lifestyle. Therefore, we are happy to submit the dental insurance claims as a courtesy to our patients to ensure that you receive the full benefits of your coverage. We are not responsible for how your insurance company handles its claims or for what benefits they will pay on a claim. We can only assist you in estimating your portion of the cost of treatment based on the information your insurance company tells us over the telephone when we call to verify your coverage. We CAN NOT GUARANTEE if your insurance will pay their estimated portion.

Ultimately, you are responsible for paying your balance, regardless of whether your insurance pays their estimated portion or not. Because the insurance policy is an agreement between you and your insurance company, we ask that all patients be directly responsible for all charges. If there are any complications, please call your insurance company. We will also assist you with any information we are able to provide in expediting payment.

FINANCIAL RESPONSIBILITY AGREEMENT

- I agree to give Creating Smiles Dental complete and accurate dental insurance information. Failure to supply the necessary information may result in the denial of my claim or delay insurance remittance.

  ***Initial*:_____**
- I will be given a *Treatment Plan Estimate* detailing my patient co-pays for any prescribed dental work. I understand that the insurance estimated amounts are based on current information collected from my insurance carrier, but DOES NOT GUARANTEE that the insurance will pay their estimated amounts.

  ***Initial*:_____**
- I understand my financial responsibilities as they relate to my dental insurance plan, and agree that I am completely responsible for the total cost of my dental treatment. Any insurance portions not paid by my insurance company are my financial responsibility to pay.

  ***Initial:*_____**
- I understand that any invoice or receipt issued by Creating Smiles Dental is a non-binding estimate only, and additional charges may apply depending upon actual payments by my insurance for dental services rendered. After my claim has been processed, I agree to pay any remaining balance on my account within 10 days upon receipt of a statement requesting payment from the dental office, or it will be considered PAST DUE.

  ***Initial:*_____**
- If I have not paid my balance within 60 days of treatment rendered, I may be charged a 1.5% per month finance charge, which will be added to my account each month until the balance is paid in full. Additionally, I may be charged all legal fees and costs if the balance goes to a collections agency.

  ***Initial*: _____**

"My signature verifies I have read, understand and am willing to comply with the Policy & Agreement, as described above."

_____	_____	_____
Print Patient's Name	Signature of Patient/Financially Responsible Party	Date
_____	_____	_____
Print Witness' Name	Signature of Witness	Date

I, (print name) _____, hereby authorize Creating Smiles Dental to take photographs, slides, and/or videos of my face, jaw, and teeth. I further understand that the photographs, slides, and/or videos will be used as a record of my part of my dental care and may be used in attempts for insurance reimbursement and to further my education as the patient.

◯ It is OK to use my photographs as part of a before and after show of treatment and for educational materials on our website and social media. If only my teeth are shown and not my face.

◯ It is OK to use my photos as part of a before and after show of treatment including my face.

◯ It is NOT OK to use my photographs as part of a before and after slideshow and for educational materials on our website.

_____ _____

Patients Signature Date

_____ _____

Witness Signature Date