Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Date of Birth:_____ SSN: _____ Family Status: _____ Driver's License #: _____
Issue State: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Mailing Address: _____
Street Apartment #

_____ E-Mail: _____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Seasonal Allergies
- Autism
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Smoker (past or present)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ **Codeine Allergy**
- ☐ **Latex Allergy**
- ☐ **Metal Allergy**
- ☐ **Penicillin Allergy**

OTHER :

- ☐ _____
- ☐ _____

Please list all prescriptions and/or over the counter medications you are currently taking:

_____

_____

Pharmacy Name: _____ **Pharmacy Number:** (_____) _____-_____

- **Are you taking any type of blood thinners?** ☐ Yes ☐ No
  If yes, please list medicine name: _____
- **Have you ever had any complications following dental treatment?** ☐ Yes ☐ No
  If yes, please explain:_____
- **Have you been admitted to a hospital or needed emergency care during the past two years?** ☐ Yes ☐ No
  If yes, please explain: _____
- **Are you now under the care of a physician?** ☐ Yes ☐ No
  If yes, please explain: _____
- **Name of Physician:** _____ Phone: _____
- **Do you have any health problems that need further clarification**? ☐ YES ☐ NO
  If yes, please explain: _____
- **EMERGENCY CONTACT:** _____ **Phone:** _____
  RELATIONSHIP: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient (friend) ☐ Another patient (relative)

☐ Internet ☐ Insurance ☐ Newspaper ☐ Postcard ☐ Other _____

Name of person or office referring you to our practice: _____

HIPAA

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Please print name

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

I give you permission to share my personal information with my Dental Insurance Company and the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please take a few moments to answer the following questions so that we can address all of your questions and concerns.

1. Are you interested in whitening your teeth?	YES	NO	UNSURE
2. Are you interested in straightening your teeth?	YES	NO	UNSURE
3. Would you like to change the appearance of your smile with veneers?	YES	NO	UNSURE
4. Would you be interested in easing TMJ pain with Botox injections?	YES	NO	UNSURE
5. Would you like to learn more about replacing missing teeth?	YES	NO	UNSURE

Other: _____

_____

_____

_____

No Show/Cancellation Policy

We recognize that everyone's time is valuable; patients and doctors alike. Failure to appear to a scheduled appointment not only compromises your health, but inconveniences other patients who may have requested an office visit during your scheduled appointment time. We also understand that emergencies happen and will do our best to accommodate you in any way that we can in case of such an emergency.

Cancellations made with less than 24 hours notice* will be documented in your chart as a missed or canceled appointment. Patients with excessive cancellations or missed appointments will be required to pay a **$75.00 deposit in order to reschedule hygiene appointments and 100% of their patient portion to reschedule restorative appointments with the doctor.** These deposits can be taken over the phone upon scheduling and will be applied on your account to use toward future treatment. A $75.00 fee will only be withheld from your deposit if you cancel or no show that appointment within 24-hours* of your scheduled appointment.

By signing here, we enter into a relationship of mutual respect for your time and ours. You are also acknowledging that you have thoroughly read and understand the no show/cancellation policy.

_____ _____

Signature **Date**

*Cancellations the day before will count as a missed/canceled appointment.

Financial Policy

Welcome to our practice and thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care using the material, technology and tools necessary to recommend personalized treatment based upon your dental needs, not based on insurance coverage. This financial policy is intended to facilitate our ability to continue to provide you with excellent dental services.

(1) Payment in full is expected at time of service.

(2) We accept cash, credit, or offer monthly payment plans via our preferred third party vendors, including Care Credit and Sunbit.

(3) Patients under the age of 18 must have an adult (guardian) above the age of 21 accompany them, and the guardian is responsible for the full payment.

(4) For unaccompanied minors, non-emergency treatment will be denied unless prior financial arrangements have been made.

Each of the following is a statement of our financial policy, which is required to be read, initialed, and signed prior to any treatment. Please initial below in agreement to the following statements before signing below:

_____ I understand that it is my responsibility to provide accurate and up to date dental insurance information.

_____ I understand that payment is due at the time of services rendered and I assume full responsibility for the charges incurred, including anything not covered by my insurance provider.

_____ I understand that the estimate given is not guaranteed to be the exact amount, since benefits cannot be fully determined until the insurance claim is filed. Your insurance is billed as a courtesy to you and although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

_____ I understand that certain procedures are not considered a covered procedure benefit under all dental insurance plans and as such, your insurance will not pay for these services. I understand I will be responsible in full for the cost of non-covered procedures.

_____ I understand that in the event of a returned check, a $35 returned check fee will be assessed to my account.

_____ I understand that if I do not make payment arrangements on any patient portion of my balance, my account will be sent to collections and accrue a collections fee totaling up to 50% of the remaining balance on the account at the time of default.

_____ I understand that if this account goes into default, I will be responsible for all court costs, attorney fees, and any other associate fees.

_____ I understand that all prior balances (excluding insurance claims pending) will need to be paid in full before subsequent services are rendered.

In certain circumstances, insurance companies may send payment directly to you. In such cases, you agree to endorse and send the check to our dental office. If you deposit the check from the insurance company, you agree to send a personal check for the equivalent amount to our office within 10 days of the deposit.

Assignment of Benefits

_____ I hereby assign all dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment directly to this office.

Authorization to Release Information

_____ I hereby authorize Outshine Family Dental to: (1) Release any information necessary to the insurance carrier regarding my care and treatment, (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature and this form to be used to process insurance claims on my behalf until revoked by me in writing.

I have read the above Financial Policy. I understand and agree to the terms stated above.

X_____ X_____ Date_____

Signature of Patient or Responsible Party Printed Name of Responsible Party