Thank you for selecting our dental healthcare team! We will strive to provide you and your family with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please contact us. We will be happy to help!

NEW PATIENT - ADULT

Patient Name: ________________________________ Date of Birth: __________ Sex: M☐ F☐
Social ________________ Driver's License: ________________ Married: ☐Yes ☐No
Home Phone: ________________ Cell Phone: ______________ Work Phone: ____________
Email: ____
Address:____
Street City State Zip Code
Preferred Method of Contact: ☐Home Phone ☐Cell Phone ☐Work Phone ☐Text ☐Email
Employer: __________________________________ Occupation: _______________________
Employer Address: ____
Street City State Zip Code
Student Status: ☐Non-student ☐Full-time ☐Part-time
Emergency Contact: _________________________ Phone: ___________________________
How did you hear about us? (Please be specific so we can thank them!)
____

*If you are completing this form for another person, what is your relationship to that person? Authorization for use or disclosure of protected health information (HIPAA Authorization):

Name: __________________________________ Relationship: ________________________

RESPONSIBLE PARTY

Name of person responsible for this account:
____
Last First MI
Relationship to patient: ______________________ Birthdate: ___________
SS#:_______________ DL#: ______________ Gender: ☐M ☐F Married ☐Yes ☐No
Work Phone:____________ Cell Phone: _____________________
Email:___________________________________
Employer: ______________________________________ Occupation: _________________________
Employer Address: ____
Street City State Zip

Are you currently a patient in our office? ☐Yes ☐No

INSURANCE INFORMATION

INSURANCE POLICY 1

Relationship to Subscriber: ☐Self ☐Spouse ☐Child
Name of Subscriber: ________________________________
Insurance Company: ________________________________ Phone: ____________________
Employer Name: _________________________ Date of Hire: _________________________
Group Name: ________________________ Group Number: _________________________
How much is your deductible? __________ How much have you used? __________
Maximum annual benefit:________

Do you have additional insurance? ☐YES ☐NO

INSURANCE POLICY 2

Relationship to Subscriber: ☐Self ☐Spouse ☐Child
Name of Subscriber: _______________________________________
Insurance Company: ________________________________ Phone: ____________________
Employer Name: _________________________ Date of Hire: _________________________
Group Name: ________________________ Group Number: _________________________
How much is your deductible? __________ How much have you used? _________
Maximum annual benefit:_________

MEDICAL HISTORY

Physician: __________________________ Office Phone Number: ______________________ Date of Last Visit:____________

		YES	NO
1.	Are you under medical treatment now?	☐	☐
2.	Have you been hospitalized for surgery or serious injury within the past 5 years?	☐	☐
	If yes, please explain:		

____

		YES	NO
3.	Are you taking any prescribed or non-prescription medications?	☐	☐
	List Medications:		

____

		YES	NO
4.	Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
5.	Do you use tobacco?	☐	☐
6.	Do you use controlled substances?	☐	☐

7. Check all medical conditions you may have or have had in the past:

☐ None
☐ AIDS/HIV
☐ Alcohol/Drug Abuse
☐ Anemia
☐ Anorexia/Bulimia
☐ Arthritis
☐ Asthma/Hay Fever
☐ Blood Clotting Problems
☐ Blood Transfusion
☐ Bronchitis
☐ Bruise Easily
☐ Cancer/Tumor or Growth
☐ Cardiac Pacemaker
☐ Chest Pain
☐ Damaged Heart Valve
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fainting Spells/Seizures
☐ Fever Blisters/Herpes
☐ Frequent Headaches
☐ Frequent Dry Mouth/Sjogren
☐ Gallbladder Problems
☐ Heart Attack/Stroke
☐ Heart Disease/Angina
☐ Heart Murmur
☐ Hepatitis/Jaundice
☐ High Blood Pressure
☐ Hives/Skin Rash
☐ Joint Replacement
☐ Kidney/Bladder Trouble
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Health Problems
☐ Mitral Valve Prolapse
☐ Persistent Cough
☐ Rheumatic Fever
☐ Rheumatic Heart Disease
☐ Sexually Transmitted Disease
☐ Sinus Trouble
☐ Stomach Ulcers
☐ Thyroid Problems
☐ Tuberculosis
☐Other:___________________
____

8. Are you allergic to any of the following?

☐ Local Anesthetic
☐ Penicillin
☐ Clindamycin
☐ Cephalexin/Keflex
☐ Sulfa Drugs
☐ Barbiturates
☐ Codeine
☐ Sedatives
☐ Iodine
☐ Aspirin
☐ Any Metals (nickel, mercury, etc.)
☐ Latex Rubber
☐ Other ________________________

9. Women ONLY:

		YES	NO
a)	Are you pregnant or think you may be pregnant?	☐	☐
	How far along are you? __________________		
b)	Are you nursing?	☐	☐
c)	Are you taking birth control?	☐	☐

DENTAL HISTORY

Name of previous Dentist: ________________________________ Date of Last Exam:____________

Reason for visit today? ____

		YES	NO
1.	Do your gums bleed when you brush or floss?	☐	☐
2.	Do you floss?	☐	☐
3.	Are you teeth sensitive to sweet or sour liquids/foods?	☐	☐
4.	Are your teeth sensitive to hot or cold?	☐	☐
5.	Do you feel pain in any of your teeth?	☐	☐
6.	Do you have sores or ulcers in or near your mouth?	☐	☐
7.	Have you had any head, neck, or jaw injuries?	☐	☐
8.	Have you experienced any of the following?	☐	☐
	a. Clicking	☐	☐
	b. Pain (joint, ear, side of face)	☐	☐
	c. Difficulty opening or closing	☐	☐
	d. Difficulty chewing	☐	☐
9.	Do you have frequent headaches?	☐	☐
10.	Do you clench or grind your teeth?	☐	☐
11.	Do you bite your lips or cheeks frequently?	☐	☐
12.	Have you had difficult extractions in the past?	☐	☐
13.	Have you had prolonged bleeding following extractions?	☐	☐
14.	Have you had any orthodontic (braces) treatment?	☐	☐
15.	Do you wear dentures or partials?	☐	☐
	How long have you had them? ________________		
16.	Do you like your smile?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Bella Smiles Cosmetic and Family Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to my dependent or myself during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Bella Smiles Cosmetic and Family Dentistry insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient (parent/guardian of patient is a minor) *Date*

Doctor Comments:

____

____

____

____

☐ *Medical Alert* ☐ *Premedication* ☐ *Allergies* Reviewed by ____________ Date _______

BELLA SMILES COSMETIC AND FAMILY DENTISTRY FINANCIAL POLICY

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial arrangements. To confirm your understanding and agreement with our policies, please read:

Payment

Payment in full is due at time of service unless prior financial arrangements are made. For your convenience, we offer several payment options:

- Cash, Debit, Visa, MasterCard, American Express, and Discover
- Pre-payment Cash Discounts
- Care Credit and Lending Club Financing
- Bella Smiles Savings Plan

Insurance

We welcome dental insurance and accept most dental plans. As a courtesy to you, we are happy to file your insurance claims and assist you in maximizing your dental benefits. We will gladly estimate your expected payment. 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. The patient is responsible for verifying their benefits and for any remaining balance. Insurance policies vary greatly. Therefore, due to the complexity of insurance contracts, we can only estimate in good faith, not guarantee coverage. As a service to our patients, we will bill your insurance company for service, and allow 45 days for them to render payment. After 60 days, you are responsible for the entire balance and it will be due in full. If you have any questions, our staff is always available to answer them.

Minors

When services are planned for minors, the accompanying parent or guardian is responsible for full payment. Responsible party must be present and sign consent at time of all services to minors.

Delinquent Payments

A service charge of 1.5% monthly on unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. All returned payments due to nonsufficient funds will be subject to a NSF fee of $40 per occurrence. Fees incurred to collect payment will be billed to and payable by the responsible party.

Missed Appointments

We request 24 hour advanced notice for any change or cancellation of your appointment. We do, however understand that illness and other emergencies occur and we do make exceptions for those rare instances. Our policy is to charge $50 for missed, broken, or no show appointments. Also, if a patient is more than 15 minutes late, there may be a need to reschedule. Repeated cancellations or missed appointments will result in loss of future appointment privileges.Please help us serve you better by keeping scheduled appointments and adhering to the cancellation policy. Thank you for putting your care and trust in Bella Smiles Cosmetic and Family Dentistry.

I ____________________ acknowledge that I have read, understand, and agree to this financial policy.

Signature ______________________________ Date _______________

PATIENT CONSENT FORM

Initial_____ Pursuant to the information contained in the Notice of Privacy Practice, I give permission of the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO). I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may contact you at any time to obtain the most current copy of the revised form.

Initial _____ I give my consent to contact me at my home or other designated location in order to speak to me directly or to leave a message with another person or mechanically regarding any matter which will assist in Treatment, Payment and Healthcare Operations. This consent will remain valid until terminated by written statement, except to the extent disclosures have been made in reliance upon my prior consent.

Initial _____ I hereby give my permission to have photographs taken during my treatment and to be used in a manner for programs and case studies that Bella Smiles Cosmetic and Family Dentistry participates in. I give my consent for these photographs to be used for educational and training purposes. I understand that my name will not be published on any of these materials beyond documentation for my chart.

Initial _____ Services are provided without regard to sex, race, color, religion, national origin, or disability.

I _______________________________ acknowledge that I have read, understand, and give consent.

Patient/Guardian Signature ______________________________ Date ________________