Bella Smiles
Beautiful Smile Beautiful You

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- CHILD

Patient Name: _____ Date of Birth: _____ Sex: M☐ F☐

Social: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Address:_____

Street City State Zip Code

Preferred Method of Contact: ☐Home Phone ☐Cell Phone ☐Work Phone ☐Text ☐Email

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

(To be filled out by parent or guardian if patient is a minor)

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

Bella Smiles
Beautiful Smile Beautiful You

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:_____

Bella Smiles
Beautiful Smile Beautiful You

MEDICAL HISTORY

Physician: _____ Office Phone Number: _____ Date of Last Visit:_____

Have you (the parent/guardian) or the patient (child) had any of the following diseases or problems?

☐ Active Tuberculosis ☐ Persistent cough greater than 3-week duration ☐ Cough that produces blood

Has the Child had any of the following:

☐ None
☐ ADHD
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Autism
☐Behavioral/Learning Problems
☐ Bladder Problems
☐ Bleeding Disorder
☐ Bones/Joint Problems
☐ Cancer
☐ Cerebral Palsy
☐ Chicken Pox
☐ Chronic Sinusitis
☐ Diabetes
☐ Earaches
☐ Eczema
☐ Epilepsy
☐ Fainting Spells
☐ Growth Problems
☐ Headaches
☐ Hearing/Speech Problems
☐ Heart Problems
☐ Hepatitis
☐ HIV/AIDS
☐ High Blood Pressure
☐ Immunizations
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Lung Problems
☐ Mononucleosis
☐ Mumps
☐ Pregnancy
☐ Psychiatric Problems
☐ Rheumatic Fever
☐ Seizures
☐ Sickle Cell
☐ Thyroid Problems
☐ Tobacco/Drug Use
☐ Tuberculosis
☐ Venereal Disease
☐Other:_____
_____

NO YES

☐ ☐ Is the child taking any of prescription and/or over the counter medications or vitamin supplements at this time?
If yes, please list: _____

☐ ☐ Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs?
If yes, please explain: _____

☐ ☐ Is the child allergic to anything else, such as certain foods?
If yes, please explain:_____

How would you describe the child's eating habits? _____

☐ ☐ Has the child ever had a serious illness? If yes, Please describe:_____

☐ ☐ Has the child ever been hospitalized? If yes, when:
Please describe:_____

☐ ☐ Does the child have a history of any other illnesses?
If yes, please list: _____

☐ ☐ Does the child have any speech difficulties?
☐ ☐ Has the child ever had a blood transfusion?
☐ ☐ Is the child physically, mentally, or emotionally impaired?
☐ ☐ Does this child experience excessive bleeding when cut?
☐ ☐ Is this child currently being treated for any illness? If yes, explain: _____

Bella Smiles
Beautiful Smile Beautiful You

DENTAL HISTORY

Previous Dentist: _____ Date of Last Visit:_____

NO	YES	
☐	☐	Is this the child's first dental visit?
☐	☐	Has the child had any problems with dental treatment in the past?
☐	☐	Has the child suffered any injuries to the mouth, head, or teeth?
☐	☐	Has the child had any problems with the eruption or shedding of teeth?
☐	☐	Has the child had any orthodontic treatment?
☐	☐	Does the child take fluoride supplements?
☐	☐	Is fluoride toothpaste used?
☐	☐	Does the child suck his/her thumb, fingers, or pacifier?
☐	☐	Does your child sleep with a bottle or sippy cup?
☐	☐	Does the child participate in active recreational activities?
		How many times of day does the child brush his/her teeth? _____
☐	☐	Do you assist with the brushing of your child's teeth?
☐	☐	Does your child floss?
☐	☐	Does your child eat or drink sweets (candy, soda, gum)?
		If yes, how often: ☐ 1-2 days per/week ☐ 3-4 days/week ☐ 5-7 days/week

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 _____

Bella Smiles
Beautiful Smile Beautiful You

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 _____

Submit Form