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 Security#: _____ Home Phone: _____ Cell Phone: _____

Race: _____ 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 Grade: _____

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

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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

Child's Weight _____ LBS. and Height _____ Inches

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: _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

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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*

Reviewed by: _____ Date: _____

Doctor Comments:

_____

_____

_____

☐ *Medical Alert* ☐*Premedication* ☐*Allergies*

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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

We do not accept personal checks as a form of payment.

Minors

The accompanying parent or guardian is responsible for full payment for minors. The responsible party must be present in order to sign any treatment consents at time of service.

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.

Appointment Cancellation Policy

We strive to render excellent dental care to you and your family. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients.

We require you to give a **48-hour notice** for any changes or cancellation of your dental appointment. Appointments scheduled on a Monday requires a **72-hour notice** and should be confirmed the Friday before your appointment. When you reserve an appointment, that time is set aside for you and when it is missed, that time cannot be used to provide treatment for another patient. Giving proper notice allows for another patient to schedule during that appointment time. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.** If a patient is more than 15 minutes late without prior notice for a scheduled appointment, this is considered a missed appointment and the $50.00 fee will be charged. 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 (print name) _____ acknowledge that I have read, understand, and I agree to abide by this financial policy.

Signature _____ Date _____

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BELLA SMILES COSMETIC AND FAMILY DENTISTRY INSURANCE POLICY

INSURANCE POLICY 1

Relationship to Subscriber: ☐Self ☐Spouse ☐Child
Name of Subscriber: _____ Date of Birth: _____
Insurance Company: _____ Phone: _____
Subscriber ID: _____
Group Name: _____ Group Number: _____

Do you have additional insurance? ☐YES ☐NO

INSURANCE POLICY 2

Relationship to Subscriber: ☐Self ☐Spouse ☐Child
Name of Subscriber: _____ Date of Birth: _____
Insurance Company: _____ Phone: _____
Subscriber ID: _____
Group Name: _____ Group Number: _____

Insurance

As a courtesy to you, we are happy to file your insurance claims and assist you in maximizing your dental benefits. All treatment plans include your insurance estimate and patient portion for dental service(s). Your insurance requires us to collect your estimated balance, as well as, unsatisfied co-pays/deductibles and charges for any non-covered services at the time of your visit. Once your insurance claim is processed, this amount may be subject to adjustment based on your dental insurances determination of benefits. It is the patient's responsibility to submit payment to the provider for any amount due as a result of healthcare services rendered by the provider. If you are covered by more than one health benefit plan, you should file all your claims with each plan. Failure to do so may violate the laws of your state, and result in collection proceeding or criminal penalties. 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. Please allow 45 days for your insurance 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.

Medicaid Members

Medicaid members have a main dentist for their dental plans and it is the patient/guardians responsibility to select a Main Dental Home dentist prior to your dental appointment. If a provider at Bella Smiles Cosmetic and Family Dentistry is not chosen as your main dentist, you will be responsible for any charges during this visit. If you change dental homes after seeing a dentist at our office please communicate this to your dental provider because your insurance will only cover dental services provided by your main dentist.

I (print name) _____ acknowledge that I have read, understand, and agree to this policy. By signing, I give consent for Bella Smiles Cosmetic and Family Dentistry to communicate with my dental insurance, as well as, submit claims and/or appeals on my behalf.

Signature _____ Date _____

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PATIENT CONSENT FORM

HIPAA CONSENT

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.

PATIENT CONTACT CONSENT

Initial _____ I give my consent to contact me by phone in order to speak to me directly or to leave a message mechanically or with another person 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.

PHOTO 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 _____DO NOT CONSENT

DISCRIMINATION DISCLAIMER

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

I (print name) _____ acknowledge that I have read, understand, and give consent.

Relationship to Patient: __Self __ Mother __ Father __ Aunt __ Uncle __Grandparent

Patient or Parent/Legal Guardian: _____ Date: _____

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PEDIATRIC DENTISTRY GENERAL CONSENT FOR DENTAL PROCEDURES AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Patient Name:	DOB:	Gender:

I hereby authorize Dr. India Gibson and the dental staff to perform upon my child, all necessary dental services he/she may need (including one or more of the following dental procedures):

__ Exam
__ X-Rays
__ Prophy (Cleaning)
__ Fluoride
__ Sealant
__ Fillings
__ Crowns
__ Bridges
__ Extractions
__ Space Maintainer
__ Root Canals
__ Wisdom Teeth Removal
__ Nitrous
__ Local Anesthesia
__ Infection Treated
__ Orthodontic Treatment
__ Other: _____

I understand, through discussions with the Doctor the nature and purpose of these procedures. Alternate procedure or methods of treatment, if any; have also been explained to me, as have their advantages and disadvantages, the risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided.

I understand that there is no guarantee that the dental procedures will be successful; however, the procedures are desired and intended to result in improved oral conditions.

I authorize the Doctor to use photographs, radiographs, other diagnostic material and treatment records for the purpose of teaching, research and scientific publications.

I agree that verbal discussions with the Doctor has outlined why the procedures are recommended, what alternative treatments are available, what risks, consequences, and complications may result from these procedures, and that all my questions have been answered satisfactorily. I also agree that all blanks above on this consent form were filled in before I was asked to sign it.

I further understand that I am free to withdraw my consent to treatment at any time and that this consent will remain in effect until such time that I choose to terminate it.

Patient or Parent/Legal Guardian: _____ Date: _____
Relationship to Patient: __Self __ Mother __ Father __ Aunt __ Uncle __Grandparent
__ Other _____
Dentist Signature: _____ Date: _____
Dental Staff Signature: _____ Date: _____