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- ADULT

Patient Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F
SS#: _____ Driver's License: _____ Married: ☐ Yes ☐ No
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Race: _____ 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
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

I am the responsible party ☐ YES ☐ NO (If no, complete the section below)

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

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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: _____ _____	☐	☐
3.	Are you taking any prescribed or non-prescription medications? List Medications: _____ _____	☐	☐

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

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
☐Cholesterol
☐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?

☐None
☐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?	☐	☐

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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 your 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*

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.

Patient or Parent/Legal Guardian: _____ Date: _____

BELLA SMILES COSMETIC AND FAMILY DENTISTRY

GENERAL TREATMENT CONSENT

DENTAL PROCEDURES

I understand that I am having the following work done:

__ Exam	__ Sealant	__ Bridges	__ Partial Denture	__ Nitrous
__ X-Rays	__Fluoride	__ Crowns	__ Complete Denture	__ Local Anesthesia
__ Prophy (Cleaning)	__ Fillings	__ Extractions	__ Infection Treated	__ Wisdom Teeth Removal
__ SRP (Deep Cleaning)		__ Root Canals		__ Other: _____

DRUGS AND MEDICATION

I understand that antibiotics and analgesics, and other medications can cause allergic reactions including redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because conditions were found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. Any changes made to your original treatment plan will affect the overall cost of treatment. I give my permission to the Dentist to make any/all changes and additions as necessary.

REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth: _____ I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain swelling spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or a fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

Tooth/teeth: _____

CROWNS, BRIDGES, AND CAPS

I understand that sometimes it is not possible too exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily, and that I must be careful to ensure that they remain on until the permanent crowns are delivered. I realize the final opportunity to make changes to my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. A crown restoration has been recommended for me on the following tooth/teeth: _____

DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new

dentures (including shape, fit, size placement and color) will be the teeth in wax try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that, occasionally, metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that, occasionally, additional surgical procedures may be necessary following the root canal treatment. Root canal treatment has been recommended for me on the following tooth/teeth: _____

PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss that can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient or Parent/Legal Guardian: _____ Date: _____

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Aunt ☐ Uncle ☐ Grandparent ☐ Other _____

Dentist Signature: _____ Date: _____

Dental Staff Signature: _____ Date: _____