Perfect Smiles Dental Care, PC- Patient Registration, Consent, and Financial Policy

Patient Name (First, M.I., Last) _____

Address_____City_____State_____Zip_____

Date of Birth_____ Social Security #_____Marital status M/S/D/W

Cell # ( ) _____ Other # ( ) _____

E-Mail address_____

Person responsible for account (If patient is a minor/unable to sign)_____

Dental insurance: Yes No

Name of Policy Holder_____ Relationship to Policy Holder_____

Employer_____ Insurance Company_____

Insurance ID or Social Security #_____ Date of Birth_____

Secondary Dental Insurance: Yes No

Name of Policy Holder_____ Relationship to Insured_____

Employer_____ Insurance Company_____

Insurance ID or Social Security #_____ Date of Birth_____

Emergency Contact Name: _____ Relationship_____ Contact #_____

How did you hear about us?

- Family/Friend:_____
- Internet(Google/Website/Facebook): _____
- Insurance Company
- Other: _____

Do you have any present dental problems? _____

How do you rate your smile?	Like to Change	It's OK	Love it
Do you avoid brushing any area of your mouth		YES	NO
Do your gums bleed when you brush		YES	NO
Are your teeth sensitive:	Hot/Cold	YES	NO
	Sweets	YES	NO
	Biting	YES	NO

Patient Signature _____Date_____

PLEASE READ AND SIGN NEXT PAGE

Consent for Treatment and Financial Policy:

I hereby authorize Dr. Davidson and/or designated staff to take necessary radiographs, study models, photos, and other diagnostic aids needed to make a thorough diagnosis of my oral condition in order to determine possible treatment needs. I authorize Dr. Davidson and staff to perform these treatment procedures after an in-depth explanation and an opportunity to ask questions. I understand that any dental procedure has risks involved including but not limited to: reactions to anesthetics (i.e., bruising, heart rate changes, and temporary or permanent 'numbness); change in 'bite'; increase in tooth sensitivity after treatment; soreness of the teeth and jaw joint; possibility of infections undetected at time of treatment; need for follow-up care and possibly follow up care and possibly further treatment. All efforts will be made to minimize such risks but I do assume these when undergoing dental care by Dr. Davidson and staff. I understand that no warranties are made as each person is individual and their bodies respond differently so each outcome cannot be specifically guaranteed.

I have been offered a copy of the HIPAA Notice of Privacy Practices and I have refused / accepted (circle one) _____ (initial)

I accept full responsibility for the payment of dental service provided by this office. I realize that dental claims are filed for me as a courtesy only. I will be given an estimate of costs which includes fees assumed to be paid by my insurance as well as the portion expected of myself. My portion of fees is due at the time of service and will not be billed. The estimate(s) given to me is based on information given to this office from my insurance company and is never a guarantee of final cost or payment from my insurance company. All reasonable efforts will be made to collect from my insurance company. If my account for dental procedural fees is not paid in full within 60 days, it is subject to billing fees by this office, collection agency fees, and any legal fees incurred by this office in order to acquire my promised payment.

You agree to reimburse us the fee of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all cost, and expenses including reasonable attorney's fees, we incur in such collection

All appointments require 24 hours' notice of cancellation. There is a $75-$150 charge for short notice cancellation

Patient Payment/Assignment of Benefits Agreement Thank you for allowing us to serve you. We are committed to providing to our patients the best possible dental care in addition to prompt and courteous service. Our services are based on dental necessity.

As a courtesy to our patients, we will file insurance claims on your behalf to the carrier(s) that you provided to us on your Patient Information Form. Patient co-payments and/or patient responsibilities are due at the time service is rendered.

We ask that you sign this agreement so we may file your insurance:

I, the undersigned, realize that all dental charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly Perfect Smiles Dental Care any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments. I have read and signed Perfect Smiles Dental Care's Notice of Privacy Practices for Protected Health Information and understand this authorizes my dentist to release to my insurance company any dental information necessary to process my claims.

Patient Signature (Parent/Guardian)_____Date_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No
Do you need to pre-medicate? Yes No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

_____

Comments:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and mu rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any times to obtain the most correct copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these restrictions. However, if you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any times. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ___ day of _____, 20___.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: Perfect Smiles Dental Care, PC

Address: 7440 North Shadeland Avenue Suite 212

City/State/Zip: Indianapolis, IN 46250

Patient Risk Assessment

All of the questions are import in helping to determine your risk of having cavities as well as gum disease. Please feel free to ask any staff member any questions you may have.

1. How many days per week do you eat candy, drink soda or energy drinks, sweeten your tea or coffee?
   1-2 3-4 5+

2. How many times per day do you brush your teeth?
   1 2 3 4

3. How many times per week do you floss your teeth?
   1 2 3 4

4. How many crowns and fillings do you have in your teeth?
   1-5 6-10 11+

Please Answer the Following Questions	YES	NO
Did you have braces?		
If yes to the above question, did you floss regularly while in braces?		
Did your parents have a lot of dental work or dental problems?		
Do your gums bleed when you brush or floss?		
Do your parents have any missing teeth or dentures?		
Do dental cleanings hurt you?		
Do you suffer from bad breath?		
Do you build tater on your teeth?		
Do you feel like you have dry mouth and want to drink a lot of drinks during the day or wake up with a dry mouth?		
Do you smoke?		
Do you take medications?		
Are you older than 37?		

5. Is the inside of your mouth pink or red?
   Pink Red
6. Is your tongue pink or brownish or white?
   Pink Brown White
7. Do you or an immediate family member (not spouse) have any of the following: Chrohn's disease, diabetes, high blood pressure, high cholesterol, hormonal diseases, cancer treatment, Sjogren's disease?