SIGNATURE SMILEZ
Family Dental

Full Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Home #: _____ Cell # _____ Email: _____

Birthdate: Day _____ Month _____ Year _____ Male or Female _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Child (under age 21) _____

Emergency contact: _____Relationship: _____ Phone #: _____

Whom may we thank for referring you? _____

How did you hear about us? ☐ Internet, ☐ Outside sign, ☐ Mail/flyer, ☐ Location, Other_____

DENTAL INSURANCE

We are willing to accept your insurance payment if the following information is provided preferably **48 hours prior** to your dental appointment so we have time to verify coverage

Do you have dental insurance: YES or NO **(PLEASE PROVIDE COPY OF INSURANCE CARD)**

Who is Responsible for the finances of your account: **SELF** or if **OTHER,** Name and Contact Information required:

_____

Name Primary Insurance _____ Policy# _____ Certificate#/ID# _____

Subscriber/Policy holders name_____ Subscribers Date of Birth:_____

Name Secondary Insurance _____ Policy# _____ Certificate#/ID# _____

Subscriber/Policy holders name_____ Subscribers Date of Birth:_____

MEDICAL HISTORY (All information is kept strictly confidential)

Are you presently under the care of a physician? If so, what is the condition being treated? _____

Have you had any serious illness or operation? _____

Have you ever been hospitalized? _____

Please list any medication you are taking: _____

Do you bruise easily or have prolonged bleeding? _____

Do you smoke? How many per day? _____

Women: Are you pregnant? _____

Are you allergic or have you reacted adversely to the following? Local anesthetic (freezing) _____

Penicillin or other antibiotics, barbiturates, sedatives, analgesics (pain killers) _____

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Do you have or have you had any of the following diseases/problems? Specify where required:

Allergies	Dizziness	High Blood Pressure	Low Blood Pressure	Stomach Problems
Anemia	Fainting	Head Injury	Liver Disease	Stroke
Arthritis	Emphysema	Heart Disease	Multiple Sclerosis	Thyroid Disease
Artificial Joints	Epilepsy	Heart Murmur	Radiation	TMJ
Asthma	Gastro Intestinal	Hepatitis A, B, C	Respiratory Problems	Tumors
Blood Disease	Glaucoma	HIV (AIDS)	Rheumatism	Ulcers
Cancer	Hard to Freeze	Hives	Sinus Problems	STD
Diabetes	Hay Fever	Kidney Disease	Anything Not Listed?_____	

DENTAL HISTORY

What is the reason for today's visit? _____

How often do you see a dentist? _____ Last Dental Visit? _____

How often do you brush per day? _____ Floss? _____ Anti-bacterial Rinse? _____

Are your teeth sensitive to cold, heat, sweets etc.? _____ Do you have bad breath /bad taste in your mouth? _____

Do your gums bleed when brushing, flossing? _____Do your gums feel tender or swollen? _____

Do your jaws crack, pop or grate when you open widely? _____Do you grind or clench your teeth? _____

Do you have food catch between your teeth? _____

Have you ever had any problems with previous dental treatments? Specify? _____

Have you had any of the following: Bridgework, Crowns or Caps, Full or Partial Dentures, Orthodontics (Braces), Periodontal (Gums), Root Canal? Specify_____

Are you satisfied with your teeth? Rate your smile on a scale from 1 (min) -10 (max)._____

What would you like to see changed? _____

GENERAL RELEASE

This is to certify that I the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures for myself and my dependents. I consent to the collection, use, retention and disclosure of personal information including photos for my chart as required for dental care. I authorize the release of my personal information regarding my diagnosis and treatment to my dental insurance for claims submitted electronically or manually. This authorization shall continue in effect until the undersigned revokes it.

PATIENT'S (PARENT'S) SIGNATURE: _____ **DATE:** _____

Thank you for choosing Signature Smilez Family Dental as your dental care provider. We promise to take great care of you.

Your insurance company pays out on the basis of the premiums you or your company pays. Your insurance may cover less than you like because the premiums paid on your plan only allow for a certain level of coverage.

Initials

_____ **For patients with one insurance policy**, we expect your co-pay (amount not covered by insurance) at each appointment. At times when we cannot precisely determine the co-pay, you may receive another invoice for the balance.

We require your credit card number on file for this.

_____ Please initial if you would like us to call you when we charge the credit card on file for your balance.

_____ **For patients with two insurance policies**, we submit to both insurances on your behalf. Depending on the plan limits, you may still have a portion to pay.

_____ **For patients with no insurance**, we encourage estimates for all services, whether you have insurance or not. To make it affordable, we have dental financing options available. ASK OUR STAFF FOR DETAILS.

_____ Your dental benefits are based upon a contract between your employer and insurance company. Most insurance policies do not cover 100% of the cost of your treatment. You may need to contact your employer or insurance company directly to determine coverage, annual maximums, frequency of services and percentages.

_____ Due to the privacy act, most insurance companies will only release information to the insurance member and not the dental clinic. We are not privy to any information regarding treatment you may have had at any other dental office. It is your responsibility to know the details of your plan.

****PLEASE REVIEW YOUR DENTAL PLAN VERY CAREFULLY TO ENSURE YOU UNDERSTAND THE EXCLUSIONS AND LIMITATIONS OF YOUR PLAN ****

_____ Preauthorization's and estimates: We can help you check your coverage prior to proceeding. These amounts are **estimated**, and do not guarantee coverage. This authorization can delay treatment.

_____ **We direct bill your insurance company as a courtesy.** We do require a credit card on file in order to submit claims to your insurance company on your behalf. If insurance does not pay within 45 days, we reserve the right to request payment in full for service from you and let you collect the insurance funds that are due to you. All overdue accounts will be subject to interest charges.

_____ Should any conditions to my dental plan change, I understand that it is my responsibility to notify the staff at Signature Smilez Family Dental.

A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must cancel or reschedule your appointment, we require at least 2 business days notice to avoid a $50-$100 cancellation fee depending on the appointment that was booked for you. If insufficient notice is given, a $50-$100 charge will be applied to your account that must be paid in order to schedule future appointments. In the rare event that there is a pattern of missed appointments, we will only book same day appointments.

Signature Smilez offers the following payment options. Please choose which option you would prefer

- **Option 1 –** This requires you to pay in full the day of treatment. We accept Visa, Mastercard, Debit or Cash. Our administrative staff will assist you in submitting claims to your insurance if necessary.
- **Option 2 –** This option allows your insurance to be billed directly on your behalf and any outstanding amounts not covered is the responsibility of the patient and will be collected day of service. For this option, please fill out the required information below.

I fully agree to the financial responsibility of any amounts not covered by my dental insurance to be applied to the credit card **(PLEASE PROVIDE COPY OF CREDIT CARD)**

Patient/Parent Signature	Date

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