allsmilesdentistry

We are so pleased you have chosen to be a part of the All Smiles Dentistry Family. We promise to be an office that you can trust. Our goal is to not only listen to your concerns but also educate you on the importance of your dental care. We are committed to providing you with the highest quality Dental Care without any pressure.

We strive for excellence in everything we do. Our team is trained and educated on the latest technology, trends and techniques. We stand behind your smile and believe in the importance of standing behind our work and to demonstrate that commitment, we'll include our warranty at no additional charge.

Once again, thank you for choosing All Smiles Dentistry. We look forward to a growing relationship with you.

Limited Dental Warranty*

Up to 5 year Warranty*
(included with your treatment)

Health Information

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Patient's Name: ____ Date of Birth: ____________________________________

Physician's Name and Phone #:____

Have you been under the care of a physician? (circle) **Yes** **No**

Have you ever been hospitalized? (circle) **Yes** **No**

Date of last dental visit: ________________________________ Date of last dental x-rays: ____________________________________

Date of last cleaning: ____________________________________ Reason for today's visit? ______________________________________

Have you ever been treated for periodontal (gum) disease? (circle) **Yes** **No**

Have you ever had a reaction to Novocaine or any other local anesthetic? (circle) **Yes** **No** Explain: ____________________________

Are you interested in tooth whitening? (circle) **Yes** **No**

If wearing dentures, age of dentures: ____________________________Are you interested in new dentures? (circle) **Yes** **No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years (circle) **Yes** **No**

Are you taking or have taken Oral Bisphosphonates? (e.g.FOSAMAX, ACTONEL, BONIVA) or IV Bisphosphonates, (e.g. ZOMETA, AREDIA) (circle) **Yes** **No** Taken for how long? ____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes** **No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes** **No** Explain: ____

List any medications you are allergic to:

1.__________________________ 2.____________________________ 3.________________________ 4.__________________________

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1.__________________________ 2.____________________________ 3.________________________ 4.__________________________

Have you ever had any of the following? Please check all that apply:

AIDS/HIV		Fainting		Pacemaker		**Female patients only:**	**Y**	**N**
Allergies or Hives		Glaucoma		Radiation treatment		Is there a possibility of pregnancy?		
Anemia		Hepatitis		Respiratory Problems		Estimated Delivery Date:		
Arthritis		Head Injuries		Rheumatic Fever		Are you nursing?		
Artificial Joints		Heart Disease		Sinus Problems		Are you taking birth control?		
Aspirin/Anticoagulant Therapy		Heart Murmur		Stomach Problems		NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.		
Asthma		High Cholesterol		Stroke				
Cancer		High Blood Pressure		Tuberculosis				
Chemotherapy		Kidney Disease		Tumors				
Diabetes		Liver Disease		Ulcers				
Dizziness		Mental Disorders		Snoring/Sleep Apnea				
Epilepsy		Mitral Valve Prolapse		Pain in your jaw (TMJ)				
Excessive Bleeding		Nervous Disorders		Use tobacco products				

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventative or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature ____ Date: _____________________________

Patient Information

Please print

First: ______________________________ Middle: ___________________ Last: ____________________________________

Address:____ City:_______________________ State:_______ Zip:_________

Home Phone: ________________________Work Phone: _____________________ Cell Phone: ________________________

Email Address: ____May we contact you by email? (circle) **Yes No**

Patient Social Security #: _________________________ Patient Date of Birth: _____________________ Sex: (circle) **M F**

Emergency Contact: ____ Phone: __________________________________

Preferred Pharmacy: ____

How did you hear about us?

O Mailer O Internet O Website O Community Event O Radio O Drive By O Insurance Company

O Friend/Family Name ____ O Other: ____________________________________

Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insured	
Subscriber Name	
Subscriber SSN	
Date of Birth	
Relationship to Subscriber:	O Self O Spouse O Child O Other
Employer Name	
Insurance Company	
Member ID	
Group #	
Insurance Phone #	
Please present your Insurance card to our front desk staff to be scanned	

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _______________________________________ Relationship to Patient: ___________________________

I give authorization to disclose the following information:

O All treatment information O Information specifically related to these treatment dates

I understand that I may withdraw or revoke my permission at any time.

Signature of Patient (or Patient Representative) ____ Date: _______________

Printed Name of Patient (or Patient Representative) ____

Financial Policies

Our patient's peace of mind is very important to the doctors and staff of All Smiles Dentistry. We understand that you want your investment to last a lifetime. We are committed to standing behind the quality of our work, and to demonstrate that commitment, will include our **WARRANTY AT NO ADDITIONAL CHARGE**. We are devoted to providing the highest quality dental care in the industry. We strive for excellence in everything we do and pride ourselves on being fair and flexible in regards to all procedures and pricing. From everyone at All Smiles Dentistry we thank you for trusting us with providing you exceptional service.

1. A Clear, Written Estimate on the Cost of Treatment

Your dentist will provide you with a comprehensive treatment plan after assessing your overall oral health. We'll provide a clear, detailed **ESTIMATE** on the cost of your treatment plan so you know what to expect including your **ESTIMATED** insurance benefits.

If you have any questions related to your insurance coverage, we encourage you to contact your insurance company.

2. Insurance

Your insurance is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will file to your primary insurance company at no charge to you. We will submit your claims and assist you in any way we reasonably can to help get your claims processed in a timely manner. In order to do this, we must receive all the information necessary to bill. If insurance payment is not received within 45 days, you will be charged the full amount with credit card on file. Any amount not covered by your insurance will be billed to you, and payment is expected within 30 days of receipt of statement.

3. Payment Policy

The following payment policies apply:

- Payment is expected at the time of service unless other financial arrangements have been made.
- A minimum 20% deposit will be collected to reserve an appointment time for comprehensive treatment.
- For reservations with our Oral Surgeon, payment for consultation must be made at the time of scheduling, and total for treatment must be paid 7 days prior to appointment.
- All Smiles Dentistry will receive all insurance payments directly.
- Acceptable forms of payment include cash, personal checks, Visa, MasterCard, American Express, Discover, Care Credit, and Lending Club.
- By signing this form, if sent to collections, you agree to pay all related fees and court costs.
- Every effort will be made to help with your insurance, but if they do not pay as expected, you will still be responsible for balance.
- Treatment plans may change, and you will be responsible for the work actually done.

4. Returned Checks

Any checks returned to our office due to non-sufficient funds (NSF) will be charged a fee of $35.

LAST MINUTE CANCELLATIONS OR MISSED APPOINTMENT FEE $35

All Smiles Dentistry is dedicated to providing quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all our patients. In return, we ask that patients make every effort not to change reserved dental appointments. When appointments are missed or little notice is given, other patients who need appointments have to wait. Also, missed or broken appointments interfere with your dental treatment. If an appointment needs to be changed we request a week notice. If a week notice is not possible we require at least a 24-hour notice so that we may accommodate other patients. A charge of $35 will be applied to broken or missed appointments without 24-hour notification. Thank you for your cooperation in this matter.

5. Notice of Privacy Practices

By signing this consent below, you consent to our use and disclosure of your protected health information. This is used to carry out treatment, payment activities and healthcare operations. Understand that your health information may be accessed by our personnel during your care at this office. All Smiles Dentistry is committed to protecting your privacy. We will only use your information as is necessary to properly diagnose and treat. By signing below, you acknowledge that we are allowed to communicate to other health care providers that we refer you to, pharmacists, and insurance providers in regards to your care.

6. Patient Satisfaction Inquiries

We are committed to providing you with exceptional service and care. If you feel you have an issue that cannot be resolved by your office team, please call Erin @ 772-336-1500 or email her at erinw@allsmilesfamilydentist.com.

7. Release Form for Media Recording/Photography

I, the undersigned, do hereby consent and agree that All Smiles Dentistry, its employees, or agents have the right to take photographs, videotape, or digital recordings of me to use these in any and all media. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to All Smiles Dentistry, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Signature ____ Date ____________________________________

Refusal Signature ____ Date _____________________________________

Receipt of Treatment Plan & Financial Policies

1. Payment, Insurance, and financial arrangement Policies (must be signed by ALL new patients).

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature ____ Date __________________________________
(If patient is a minor or disabled, the Parent/Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

2. Notice of Privacy Practices (must be signed by ALL new patients).

By signing below, I acknowledge that I have read the Notice of Privacy Practices as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Signature ____ Date __________________________________
(If patient is a minor or disabled, the Parent/Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

3. Release of Information to Insurers and Assignment of Benefits (must be signed by ALL new patients with Insurance and those who expect to obtain Insurance).

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature ____ Date __________________________________
(If patient is a minor or disabled, the Parent/Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

Responsible Party (if patient is under 18 or disabled)

Circle One: Dr/Mr/Mrs/Ms/Miss

First: ______________________________ Middle: ___________________________ Last: __________________________________

Address: ______________________________________ City: ____________________________ State: ________ Zip: __________

Home Phone: (______)_________________Work Phone: (_______)_________________Cell Phone: (_______)_______________

Patient SSN# __________-________-__________ Patient Date of Birth: ________/________/________ Sex: (circle) M F

Signature:____Date:_________________________