

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** Female patients, are you pregnant? (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** Do you snore? (circle) **Yes No** Do you use a CPAP machine? (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. _____

AIDS/HIV		Fainting		Pacemaker	
Allergies or Hives		Glaucoma		Radiation treatment	
Anemia		Hepatitis (circle) A B C		Respiratory Problems	
Arthritis		Head Injuries		Rheumatic Fever	
Artificial Joints		Heart Disease		Sinus Problems	
Aspirin/Anticoagulant Therapy		Heart Murmur		Stomach Problems	
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**

Marital Status (circle): **Married Single Head of Household Child**

Emergency Contact: _____ Phone: _____

Preferred Pharmacy: _____

How did you hear about us?

Mailer Internet Website Community Event Radio Drive By Insurance Company

Friend/Family Name _____ 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:	<input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other
Employer Name	
Insurance Company	
Member ID	
Group #	
Insurance Phone #	
Please present your Insurance card to our front desk staff to be scanned	

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. Our detailed **ESTIMATE** is based on preliminary information provided by your insurance company.

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. 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.
- If payment is not received within 45 days of treatment, you will be charged the full amount to the credit card listed on file.

4. Returned Checks

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

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 Raeanne Hansen @ 561-714-4147 or email her at Raeanne.H@allsmilesfamilydentist.com.

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.

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)

Credit card number

Expiration date

Authorization code

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: _____

