PERFECT SMILES
FAMILY DENTISTRY

Confidential Information

1 Patient Information

Name: .....

I prefer to be called: ..... ☐ Male ☐ Female

Date of Birth: ..... SSN: .....

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

Home Address: .....

.....

Email: ..... ☐

Home: ..... ☐ Cell: ..... ☐

Work: ..... ☐ Profession: _____

Employer/School: .....

Employer/School Address: .....

.....

Spouse/Guardian's Name: .....

Whom may we thank for referring you? .....

☐ Yellow Pages ☐ Magazines ☐ Mailers ☐ Friend
☐ Family ☐ Yahoo! ☐ Google ☐ Other

2 Responsible Party

Person Responsible for this Account: .....

Relationship to Patient: .....

Date of Birth: ..... SSN: .....

Address: .....

.....

Email: ..... ☐

Home: ..... ☐ Cell: ..... ☐

Work: ..... ☐

Driver's License: ..... Employer: .....

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ Visa ☐ MasterCard
☐ Health Loan Service ☐ I wish to discuss the office's payment policy

Emergency Contact Name: .....

Home: ..... ☐ Work: ..... ☐

3 Insurance Information

Primary Insurance

Name of Insured: ..... Relationship to Patient: .....

Birthdate: ..... SSN: ..... Date Employed: .....

Employer: ..... Union or Local#: ..... Employer's Phone: .....

Employer's Address: ..... City/States/Zip: .....

Insurance Company: ..... Group/Policy/ID#: ..... Insurance Co. Phone: .....

Insurance Co. Address: ..... City, States, Zip: .....

Secondary Insurance

Name of Insured: ..... Relationship to Patient: .....

Birthdate: ..... SSN: ..... Date Employed: .....

Employer: ..... Union or Local#: ..... Employer's Phone: .....

Employer's Address: ..... City/States/Zip: .....

Insurance Company: ..... Group/Policy/ID#: ..... Insurance Co. Phone: .....

Insurance Co. Address: ..... City, States, Zip: .....

Signature on file:
Perfect Smiles Family Dentistry is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

X _____ Date: _____

Patient or authorized person's signature

Confidential Information

4 Patient Medical History

		Yes	No
1.	Do you have a personal physician?	☐	☐
	a) Physician's Name: _____		
	b) Physician's Office Phone: _____		
	c) Date of Last Exam _____		
2.	Are you under medical treatment now?	☐	☐
3.	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
4.	Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
5.	Have you ever taken Fen-Phen/Redux?	☐	☐
6.	Do you use tobacco?	☐	☐
7.	Do you use controlled substances?	☐	☐
8.	Do you have or have you ever had any of the followings?		

	Yes	No
9. Do you use contact lenses?	☐	☐
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐
11. Do you have a persistant cough or throat clearing not associated with a known illness? (lasting more than 3 weeks)	☐	☐
12. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

13. Do you take or have taken Bisphosphonate Drugs.....__Yes __No

	Yes	No		Yes	No		Yes	No
AIDS or HIV Infection	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Hay Fever / Allergies	☐	☐	Radiation Therapy	☐	☐
Angina	☐	☐	Heart Attack	☐	☐	Recent Weight Loss	☐	☐
Arthritis	☐	☐	Heart Murmur	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Heart Trouble	☐	☐	Sexually Transmitted Disease	☐	☐
Cardiac Pacemaker	☐	☐	Hepatitis / Jaundice	☐	☐	Shortness of Breath	☐	☐
Chest Pains	☐	☐	High Blood Pressure	☐	☐	Stomach Troubles / Ulcers	☐	☐
Diabetes	☐	☐	Joint Replacement / Implant	☐	☐	Stroke	☐	☐
Emphysema	☐	☐	Kidney Diseases	☐	☐	Swollen Ankles	☐	☐
Epilepsy / Convulsions	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐
Fainting / Seizures	☐	☐	Liver Disease	☐	☐	Thyroid Problem	☐	☐
Frequently Tired	☐	☐	Low Blood Pressure	☐	☐	Other _____	☐	☐

5 Patient Dental History

		Yes	No
1.	Do your gums bleed while brushing or flossing?	☐	☐
2.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4.	Do any of your teeth hurt?	☐	☐
5.	Do you have any sores or lumps in or near your mouth?	☐	☐
6.	Have you had any head, neck, or jaw injuries?	☐	☐
7.	Have you ever experienced any of the following problems in your jaw?		
	Clicking	☐	☐
	Pain (joint, ear, side of face)	☐	☐
	Difficulty in opening or closing	☐	☐
	Difficulty in chewing	☐	☐

		Yes	No
8.	Do you have frequent headaches?	☐	☐
9.	Do you clench or grind your teeth?	☐	☐
10.	Do you bite your lips or cheeks frequently?	☐	☐
11.	Have you ever had any difficult extractions in the past?	☐	☐
12.	Have you ever had any prolonged bleeding following extractions?	☐	☐
13.	Have you seen an orthodontist for treatment?	☐	☐
14.	Do you wear dentures or partials?	☐	☐
	If yes, how old are they? _____	☐	☐
15.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16.	Do you like your smile?	☐	☐

I certify that I have read and understand the above. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be harmful to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child 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 **Perfect Smiles Family Dentistry** or dental group 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 on behalf of my dependents.

X _____ Date: _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments: _____

_____ Date: _____

_____ Date: _____

A NOTE TO OUR PATIENTS REGARDING OUR OFFICE POLICIES

Appointment Confirmations: Our office will make confirmation phone calls or send a text /email message to each scheduled patient at least two (2) days prior to their appointment. If we are unable to speak to you directly to confirm your appointment, **please pay us the courtesy of returning our call, text or email to confirm your appointment.**

Cancellation Policy: We reserve time especially for you with our doctor and/or hygienist. If you need to change your appointment, we kindly ask for a **minimum of 24 hours** so we can accommodate our other patients. Patients will be assessed a fee of **$50.00** for any cancellation or no-show to your scheduled dental appointments, as well as for all subsequent late cancellations or no-shows. This fee will be automatically billed to the patient and will be due before that patient's next appointment can be scheduled. *Consecutive missed appointments can result in being dismissed as a patient.*

Consent to Treatment: The undersigned hereby authorizes our doctor and or hygienists to perform necessary diagnostic and treatment procedures, including local anesthesia and sedation deemed necessary. **Should you ever have any health changes or change in medication, please inform the doctor during your next appointment.**

Financial Policy: We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the financial policy, please do not hesitate in discussing them with us.

As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co-payments and non-covered amounts are due at the time services are rendered. All estimates quoted are based upon information provided to us by your insurance company and are **ESTIMATES ONLY and DOES NOT GUARANTEE PAYMENT** by your insurance company. The final determination of payment will be made by your insurance benefits provider at the time the claim is processed. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. The patient is ultimately responsible for all charges incurred.

_____ I understand that my dental benefits plan may pay less than the actual bill for services and that I am fully responsible for payment of my account. I have read and understand the financial policy of the practice and I agree to be bound by its terms.

Insurance companies are required by law to pay claims within 30 days. After 60 days, any unpaid claims will be resubmitted by our office and we ask that you pay in full and have your insurance company reimburse you. We will be happy to provide any information or documentation you may require. Our estimates are subject to final approval by your insurance company; therefore, the amount due to our office is subject to change. The final determination of payment will be made by your insurance benefits provider at the time the claim is processed.

*Your estimated patient portion must be paid at the time of service. Any and all residual balances are ultimately the responsibility of the patient.

WE DO NOT RENDER OUR SERVICES ON THE BASIS THAT INSURANCE COMPANIES WILL PAY OUR FEES. ULTIMATELY ALL DENTAL FEES ARE THE RESPONSIBILITY OF THE PATIENT.

❖

As witnessed by my signature, I hereby acknowledge and accept the Office Policies of Perfect Smiles Family Dentistry.

Patient Signature _____Date _____

Acknowledgment of Receipt of Dental Material Fact Sheet

I acknowledge that I have received from Perfect Smiles Family Dentistry, the Dental Materials fact Sheet that was updated on April 4, 2020.

Print Name:_____

Signature:_____ Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgment if you wish.
I acknowledge that I have received a copy of the Notice of Privacy Practices from Dr Bruce Farrell.

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature: _____Date:_____

I _____authorize you to speak to/and or share information regarding my Dental Health/Records with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify) _____

_____

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