Modern Smile Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient Name:_____ Prefers to be Called By: _____
(Title First MI Last)

Sex: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other: _____

Address: _____
(Street Apt. # City State Zip Code)

Phone (H): _____ (W): _____ Ext: _____ (C): _____

Social Security #: _____ Date of Birth: _____ E-mail Address: _____

In case of emergency, contact: _____ Phone: _____ Relationship: _____

Responsible Party Information (If Other Than Patient)

Name:_____ Relationship to Patient: _____
(Title First MI Last)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Address: _____
(Street Apt. # City State Zip Code)

Phone (H): _____ (W): _____ Ext: _____ Best Time to Call: _____

Social Security #: _____ Date of Birth: _____ E-mail Address: _____

Insurance Information

Primary Insurance Information:_____ ID # / SS #:_____

Name of Insured: _____ Is insured the patient? ☐ Yes ☐ No
(Title First MI Last)

If not, patient's relationship to insured: ☐ Spouse ☐ Child ☐ Other: _____

Insured's Date of Birth: _____ Group #: _____

Insured's Address: _____
(Street Apt. # City State Zip Code)

Insured's Employer Name: _____ Occupation: _____

Secondary Insurance Information:_____ ID # / SS #:_____

Name of Insured: _____ Is insured the patient? ☐ Yes ☐ No
(Title First MI Last)

If not, patient's relationship to insured: ☐ Spouse ☐ Child ☐ Other: _____

Insured's Date of Birth: _____ Group #: _____

Insured's Address: _____
(Street Apt. # City State Zip Code)

Insured's Employer Name: _____ Occupation: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

_____

Signature of Patient or Legal Guardian Patient/Legal Guardian Name Printed Patient Name

Modern Smile Dental

Referral Information

Whom may we thank for referring you to our practice? Name of person or office referring you to our practice: _____

Dental History

Patient Name: _____
Title First Middle Last

Reason for Today's Visit: _____

Former Dentist: _____ Address: _____

Date of last dental care: _____ Date of last dental x-rays: _____

Have you ever had a bad dental experience? If yes, explain:_____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity when biting
- ☐ Sensitivity to hot or cold
- ☐ Sensitivity to sweets
- ☐ Do you snore
- ☐ Do you have Sleep Apnea
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____ Are you happy with your smile? _____

Medical History

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cholesterol (High)
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Chemical Sensitivity
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet / Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

OTHER PROBLEMS NOT LISTED ABOVE: _____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

SUPPLEMENTS/HERBALS: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

_____

Signature of Patient or Legal Guardian Patient/Legal Guardian Name Printed Patient Name

Modern Smile Dental

Insurance Information

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense. **Insurance is a method of payment not a method of treatment.** Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

It often takes us a considerable amount of time to try to collect your insurance payment for you. We often need your help to discuss your situation directly with your insurance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, we cannot render services on the assumption that our charges will be paid by an insurance company. In addition, this form also authorizes this practice to submit insurance claim forms and receive payments directly from the Insurance carrier with the notation "SIGNATURE ON FILE".

Financial Agreement

If an account is outstanding for more than sixty (60) days, a monthly service charge of 1.5% may be added to the balance. If the account is not cleared within the time specified, the account will be turned over to our collection service with additional charge of 25% towards the pending balance and a report may be filed with a credit servicing agency, such as Equifax. **Insurance co-payments and deductibles are due at the time of service.**

I Understand That Payment Is Due At Time of Service

Signature of Parent or Legal Guardian _____ Date_____

Cancellation or Broken Appointment

Your time is as valuable as ours. We make every effort to see you at your reserved time. We apologize in advance if you are not seen exactly at your scheduled time; please understand that we do try to work-in dental emergencies.

As a courtesy we attempt to confirm each scheduled appointment, however, as the patient you are responsible to keep up with your reserved time and are still subject to the cancellation/broken appointment fee should you not make it to your appointment. Please inform us if any address or contact information needs to be updated.

Consent

- I hereby authorize and direct the dentists of Modern Smile Dental and/or dental auxiliaries of their choice, to perform upon my child (or legal ward) treatment that is necessary or recommended.
- I authorize my Dentist(s) to release treatment records/ x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or treatment.

I acknowledge that the practice may send the following electronic communications:

- Information about my invoice or accounts payable upon request, to patient/legal guardian
- Information about a specific dental visit
- digital x-rays, referrals and/or orders to a dental specialist about treatment

I have read and understand the above and acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

Signature of Patient or Legal Guardian | Patient/Legal Guardian Name Printed | Patient Name