Pilsen Smiles

FAMILY DENTISTRY

Patient Information:

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Gender:_____Married: _____ Single: _____

SS#: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

E-mail address: _____ Best way to reach you: _____

Employer: _____

Emergency Contact: _____ Phone #: _____

Other family members seen by us: _____

How did you hear of us? _____

If referred by someone, whom may we thank for the referral? _____

Parent/Guardian Information (if patient is a minor):

Name: _____ Relationship to patient: _____

Birth Date: _____ SS#: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Dental Insurance Information (Primary):

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Dental Insurance Information (Secondary):

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Do you like your smile? Yes/No

What, if anything, would you change about your smile? _____

Why have you come to the dentist today? _____

Are you currently in pain? Yes/No Do your gums bleed? Yes/No How many times a day do you brush? _____

Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? Yes No

Have you ever had problems with previous dental treatment? Yes No

If yes, please explain: _____

Previous Dentist or Dental Office: _____ When was last dental visit? _____

Do you smoke or use chewing tobacco? Yes/No If yes, how long? _____ How often? _____

Physician's Name: _____ Phone #: _____

Have you ever had a serious head, neck, or back injury? _____

***Have you ever tested positive for COVID-19? _____ If so, dates: _____**

WOMEN: Are you or could you be pregnant? Y/N Are you nursing? Y/N Taking Oral Contraceptives? Y/N

Are you currently being treated for or have you ever been treated for any of the following? Please circle all that apply:

Arthritis	Cancer/Chemo	Heart Attack/Stroke	Any implant /Transplant	Rheumatic Fever
Artificial Valve/Joint	Diabetes	Heart Murmur	Kidney Problems	Severe Headaches
Asthma	Drug/Alcohol Abuse	Heart Surgery	Low Blood Pressure	Sinus Problems
Autism	Epilepsy/Seizures	Hepatitis	Mitral Valve Prolapse	Thyroid problems
Bruise easily	Excessive Bleeding	High Blood Pressure	Pacemaker	Tuberculosis
Blood Transfusion	Glaucoma	HIV/AIDS	Psychiatric Care	

Please list any medical condition not listed above: _____

Are you allergic to any of the following? PLEASE CIRCLE YES or NO FOR EACH ONE.

Latex: Y/N	Penicillin: Y/N	Aspirin: Y/N	Erythromycin: Y/N	Codeine: Y/N
Tetracycline: Y/N	Ibuprofen: Y/N	Tylenol: Y/N	Sulfa: Y/N	Dental Anesthetics: Y/N

Other _____

Please list all medications you are currently taking:

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: _____

Date: _____

Parent/Guardian Signature (**if patient is a minor**): _____ Date: _____

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Office Financial Agreement Policy

Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Insurance

- Your insurance policy is a contract between you and your employer and/ or insurance provider. We are not a party of that contract; however, we are happy to serve as a liaison and file your claim to your insurance company for you.
- If you are covered by one of our accepted insurance plans, we require a credit card on file. The patient will be responsible for paying the percentage of outlines fees set by their insurance company at the time of service. If your insurance company has not paid your account in full within (1) billing statement, you will then be responsible for the remaining balance in which we will then charge your card on file.
- Please be aware that some, and perhaps, all of the services provided may be non- covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to recommending the best treatment for our patients regardless of coverage. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Your insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. As a reminder, all fees are due at the time of service.
- If sent to collections, I agree to pay all related fees and court costs.

Cancelation and Rescheduling Policy

When we schedule an appointment, that time is reserved solely for you and we make every effort to see you on time for this reason, we ask that you arrive a few minutes before your scheduled time. If you are late, it may be necessary to reschedule your visit.

- I understand that deposits are required to reserve an appointment time 4PM and later for weekday appointments as well as Saturday appointments. We also require a 48-hour notice for cancelations to allow us enough time to contact another patient from our waiting list to fill the appointment slot. If we do not receive a 48-hour notice, we reserve the right to charge your credit card a missed appointment fee of $50.00-$100.00
- The missed appointment fees must be paid prior to future office visits.

I have read, understand and agree to this policy.

Print Name: _____

Signature: _____ Date: _____

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Agreement to Financial Policy

We have a new financial policy that applies to ALL in-network and out-of-network patients. We now require a credit card on file so you have one less thing to worry about and allows us to charge your card on file for any copays, balances, deposits and cancellation fees. Our office accepts MasterCard, Visa & Care Credit.

When in situations where your insurance provider pays its portion, and leaves you accountable for the remaining balance, **you will be responsible to submit this payment within 5 business days receipt of (1) billing statement. If no payment is received, your payment will be charged to your credit card information on file with Pilsen Smiles and will be processed for the balance on your account.**

Credit Card Information:

Name of Cardholder: _____

Card Type: MasterCard _____Visa _____Care Credit_____

Credit Card Number: _____ **Exp. Date:**_____**CVC:**_____

Authorized Signature: _____**Date:** _____

Name of Patient(s):_____

I hereby authorize Pilsen Smiles to bill the credit card I have provided above to keep on file for services rendered, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer.

I have read, understand and agree to the policy.

Print Name:_____Signature:_____

Date: _____

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HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

The Consent was signed by: _____

Printed Name. Patient or Representative

Relationship to Patient

(if other than patient): _____

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CONSENT TO DENTAL PHOTOGRAPHY

Date: _____

I, _____ (authorize/ Do Not authorize) Pilsen Smiles to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following

- *Dental records*
- *Dental research*
- *Dental education including lectures, seminars, professional publications such as journals or books*
- *Online dental forum publication*
- *Marketing material, including websites and printed materials, patient education*
- *Social Media*
- *"Before and After" Photo Album*

The photos/videos will show: FULL FACE/MOUTH

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential (other than if Full Face photographs are used).

Signature (Patient) _____

Signature (Dentist) _____