Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Diabetes
- Dizziness
- Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Jaundice
- Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- Pregnancy
- Due date:_____
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- Venereal Disease
- Codeine Allergy
- Penicillin Allergy

OTHER:
_____

_____

- Have you ever had any complications following dental treatment? Yes No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
  If yes, please explain: _____
- Are you now under the care of a physician? Yes No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

InSmile Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the **Notice of Privacy Practices** of this office.

_____
Name (Please Print)

_____ _____
Signature Date

Please Note: It is your right to refuse to sign this acknowledgement.

_____
Office Use Only

We tried to obtain written acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ A communication barrier prevented us from obtaining acknowledgement.
- ☐ The individual was unwilling to sign.
- ☐ Other:

_____
_____
_____
_____

BROKEN APPOINTMENT POLICY

When you reserve a time with us please make every attempt to make your appointment. We do not "double book" as many offices do. This time is set aside specifically for you. One week prior to your appointment you will receive an email, text message or a phone call if you do not wish to receive text messages. When you receive this message, please call, text or email us to confirm the time that you have already reserved with us. We have ***24 hours cancellation policy***. If you need to change or reschedule your reserved time with us, please give us at least ***1-business day notice*** so that we will be able to fill this time with others waiting for treatment. If you cancel, fail to show for your confirmed appointment, or you arrive excessively late and treatment cannot be completed as planned, we recover our lost opportunity and associated costs for having our Staff on standby with a ***Broken Appointment Fee ($50)***. This may sound harsh, but please understand that if you have numerous broken appointments, we reserve the right to release you as a patient and ask that you seek treatment at another Dental Practice. Thank you for understanding this policy.

LATE ARRIVAL

If you are over ***15 minutes late*** for your appointment, we reserve the right to reschedule your appointment for a later time. The ***Broken Appointment Fee of $50*** will apply to this as well. Please understand that we strive to stay on time for your appointment as well as those patients that follow you. By signing below, you have read, and understand this agreement.

_____Signature of Patient or Parent _____ Date