Welcome to Elite Smiles Dental!

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Preferred Name: _____

Address: _____ Social Security #: _____

_____ Home Phone #: _____

_____ Cell Phone #: _____

Age: _____ Sex: _____ Marital Status: _____ Work Phone #: _____

E-mail: _____ (will only be used for office communications)

Whom may we thank for referring you? _____

If you were referred to our office by a current patient outside of your immediate family, our CARE TO SHARE program allows you both to earn a $25 credit on your accounts!

EMERGENCY CONTACT / RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Home Phone #: _____

_____ Cell Phone #: _____

Relationship to Patient: _____ Work Phone #: _____

E-mail: _____ (will only be used for office communications)

Is this person currently a patient in our office? _____

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____

_____ Social Security #: _____

Employer: _____ Phone #: _____

Address: _____ Union or Local #: _____

_____ Group #: _____

Insurance Co: _____ Phone #: _____

Address: _____ Member ID #: _____

_____ Family/Single coverage: _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Policy Holder: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____

_____ Social Security #: _____

Employer: _____ Phone #: _____

Address: _____ Union or Local #: _____

_____ Group #: _____

Insurance Co: _____ Phone #: _____

Address: _____ Member ID #: _____

_____ Family/Single coverage: _____

Welcome to Elite Smiles Dental!

PATIENT MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____ Date of Last Exam: _____

Have you ever been told you have one of the following? Check only if answer is yes.

___ Heart Disease	___ Anemia	___ Asthma	___ Heart Murmur	___ Congenital Heart Defect
___ Bleeds Easily	___ Swollen Ankles	___ Heart Attack	___ Shortness of Breath	___ Joint Replacement/Implant
___ Fainting/Seizures	___ AIDS/HIV	___ Arthritis	___ Chest Pain - Angina	___ Recent Weight Loss
___ Hay Fever/Allergies	___ Emphysema	___ Cancer	___ Epilepsy/Convulsions	___ Psychiatric Treatment
___ Kidney Disease	___ Rheumatic Fever	___ Diabetes	___ High Blood Pressure	___ Radiation Therapy
___ Liver Disease:	___ Stomach Ulcer	___ Stroke	___ Low Blood Pressure	___ Mitral Valve Prolapse
___ Hepatitis	___ Thyroid Disease	___ Glaucoma	Leukemia	___ Sexually Transmitted Disease:
___ Jaundice	___ Other: _____			_____

Do you have any allergies to any medications? _____

YES	NO	
_____	_____	Are you under any medical treatment now? If yes, please explain: _____
_____	_____	Have you ever had any other serious illness not listed above? If yes, please explain: _____
_____	_____	Are you currently taking any medications? If yes, please explain: _____
_____	_____	Have you ever had a bad reaction to local anesthetic or penicillin? If yes, please explain: _____
_____	_____	Do you use tobacco? If yes, please explain: _____
_____	_____	Do you use alcohol, cocaine, or other drugs? If yes, please explain: _____
_____	_____	*For women only:* Are you pregnant or think you may be pregnant? If yes, please explain: _____
_____	_____	*For women only:* If not, are you currently using birth control? _____

PATIENT DENTAL HISTORY

Previous Dentist: _____ Phone #: _____ Date of Last Exam: _____

Location: _____ Date of Last Cleaning: _____

What is the reason for your visit today? _____

Do you have any pain or discomfort now? Please explain: _____

Do your gums bleed? _____ Have you ever had surgery performed on your gums? _____

Have you ever had a root canal? _____ Have you ever worn braces? _____ Do you wear Dentures? _____

Do you clench or grind your teeth? _____ Have you ever had any trauma to your face or mouth? _____

Do you floss? How often? _____ How many times per day you brush your teeth? _____

Are your teeth sensitive to hot or cold liquids? _____ Are your teeth sensitive to sweet or sour liquids/foods? _____

Do you have any sores or lumps in or around your mouth? _____ Do you like your smile? _____

Have you ever had prolonged bleeding after extractions? _____ Do you bite your lips or cheeks frequently? _____

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. I authorize and request my insurance company to pay directly to Elite Smiles Dental any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and Elite Smiles Dental has no leverage on assuring that my claims will be paid as estimated. As a courtesy to their patients, Elite Smiles Dental completes and files my insurance claims for me. I understand that I am responsible for any unpaid or denied claims. *Thank you for understanding that as your dental care provider, our relationship is with you and not with your insurance company.*

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 payers and/or health practitioners. I understand that Elite Smiles Dental complies with all HIPAA policies and regulations and that I may request a detailed outline of such policies.

_____ _____ _____

(Please Print) Name of Patient | Signature of Patient/Parent or Guardian | Today's Date

_____

Signature of Treating Dentist

Welcome to Elite Smiles Dental!

FINANCIAL POLICY

Thank you for choosing Elite Smiles Dental as your dental care provider. Our office is committed to providing you with the highest quality dental care. Please understand that payment of your bill is considered as 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. We do provide many payment options to accommodate our patient's needs. ***Please discuss your options with our staff to find the solution that is best for you.***

Payment Options

I have Dental Insurance (please circle one):

1. I would like to pay my estimated portion by cash or check at the time of service
2. I would like to pay my estimated portion by credit card at the time of service
3. I would like to apply for an extended payment plan so that I may take up to three years to pay

I do not have Dental Insurance (please circle one):

1. I would like to pay by cash or check at the time of service
2. I would like to pay by credit card at the time of service
3. I would like to apply for an extended payment plan so that I may take up to three years to pay

Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits or your insurance company has not paid your account in full within 60 days, the balance will be transferred to your account. 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 providing the highest quality dental treatment for our patients and we charge what is the 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 complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

As a courtesy to all patients we will verify your dental insurance benefits, ***but you are responsible to know your plan coverage, exclusions and limitations.*** Furthermore, you should be aware of non-covered benefits including but not limited to missing tooth, crown/bridge/denture restorations, bruxism, downgraded limitations for fillings and porcelain on crowns for molar teeth, frequency limits for exams, prophylaxis, floured and x-rays. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check or credit card. We also offer extended payment plans upon qualification. ***All estimates are subject to final approval by your dental insurance plan, therefore the amount due is subject to change after final review by your insurance company.***

_____Initial

Welcome to Elite Smiles Dental!

INITIAL PAYMENT FOR DENTAL TREATMENT: Most plans cover routine clinical exams and cleaning without requiring a deductable for diagnostic or preventative treatment; however, some plans do require a co-payment for x-rays and dental exams. Deductibles (payment due by the patient) are customarily charged for some procedures including, but not limited to: fillings, crowns, extraction, root canal therapy and periodontal treatment. Co-payments and deductibles are due prior to any service being performed.

- Appointments two hours or longer: a 50% deposit is required in order to schedule any treatment two hours or longer.
- Lab Fees are an additional cost for procedures requiring specific materials or advanced techniques (veneers, all-porcelain crowns, porcelain margins, etc.) You will be advised on any additional lab costs prior to the start of treatment.

_____Initial

RESIN-BASED COMPOSITE RESTORATIONS (Fillings): Most dental insurance plans do not allow full benefits for composites (white fillings) performed on posterior teeth (back molars). The plan benefit will customarily pay for less expensive treatment called an Amalgam (silver/mercury based). In an effort to provide our patients the highest level of modern dental care, we do not Amalgams, rather only composite fillings. The difference is usually $50-75 per filling and the patient is responsible for the difference in cost.

PULP-CAP TREATMENT (medication to protect the pulp chamber): Most dental plans do not allow additional benefits for pulp-cap treatment (the procedure in which the filling is very deep and the nearly exposed pulp is covered with a protective medication to help with healing and repair via formation of secondary dentin). At ESD we do this treatment when medically indicated because we only want to provide the highest level of dental care for our patients. The cost of this treatment is $20-53 per tooth depending on the extent of treatment. If your insurance does not cover the charges or does not allow a separate charge, you will be responsible for payment for this service.

_____Initial

RESERVATIONS: At least 50% of a patient's estimated portion will be required to schedule appointments two hours in length or longer; this deposit is nonrefundable if the patient misses the appointment without at least 48-hours notice.

MISSED APPOINTMENT FEE: Elite Smiles Dental does charge a missed appointment fee of $50 per half hour of appointment time for all appointments not given at least two business days (48hrs) advance notice. Please call us immediately once you realize that you cannot keep your appointment.

CHARGES: All returned checks are subject to a $35 fee. All balance over 60 days are subject to interest in the amount of 1.5% per month. We reserve the right to apply a $25 rebilling fee and a $25 late charge, for any overdue payments. We have the option to report your overdue balance to any credit reporting agency or credit bureau.

PAST DUE AMOUNTS: Any accounts over 90 days past due will be turned over to a collection agency or attorney; you agree to pay all fees including but not limited to attorney fees, court costs and collection agency fees.

TRANSFERRING RECORDS: Elite Smiles Dental requires that you submit a written request in order to transfer any or all of your dental records. We require at least 24 hours to complete the transfer as requested. We require at least three (3) business days if your record is more than two years old and stored in the company archive. The cost of duplicated/printed x-rays is $5.00 for a single PA x-ray, $15.00 for bite-wings, $25.00 for full mouth x-rays or Panoramic x-rays. Copying and printing fees are $25.00 per record in addition to the x-ray fees if applicable. The fee is waived if we are referring you to a specialist.

_____Initial

Thank you for understanding our Financial Policy. I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY. ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I AGREE TO ABIDE BY THIS FINANCIAL POLICY.

(Please Print) Name of Patient	Signature of Patient/Parent or Guardian	Today's Date

Welcome to Elite Smiles Dental!

Please Handle Me With Care…

Patient's Name: _____

Please CIRCLE the number next to the statements that concern you or describe your situation:

1. I have not been to the dentist for a long time, and I feel worried about what you will say about my teeth and my oral hygiene.
2. My teeth are very sensitive.
3. Pain relief is a top priority for me.
4. I'm very anxious about injections.
5. I feel out of control in the dental chair (or I have an extreme problem with lying down).
6. I gag easily.
7. I hate the noise of dental instruments.
8. I hate the sight and/or smell of a dental office.
9. I have a preference for male or female dentist: _____.
10. Please tell me about the treatment options and the ways these can be carried out.
11. I need to know that you will stop when I give a pre-agreed "stop" signal during treatment.
12. It would help me if you could explain to me what you are doing and why.
13. I have health problems that we need to discuss.
14. I am feeling more stress and anxiety in my life now, than in the past.
15. There are other issues I'd like to talk about that aren't covered on this form:

    _____

    _____

    _____

    _____

16. What special things can we do in our office to make sure you are well cared for?

    _____

    _____

    _____

Welcome to Elite Smiles Dental!

Patient Smile Assessment

Please answer the following questions about your daily routine and your current smile.

Patient's Name: _____

1. *Please describe the types of interactions you have with others on a daily basis.*
   - ☐ I work in front of large groups of people (such as public speaking or performing).
   - ☐ I work in close proximity to others (such as in the health care industry or in sales).
   - ☐ Sometimes I interact with groups of people; other times I work more closely with individuals (such as teaching or working in a corporate environment).
   - ☐ I do not regularly interact with other people.

2. *All treatment options will require regular and follow-up appointments – some more than others. How flexible is your schedule when it comes to scheduling appointments?*
   - ☐ Very flexible; I manage my own schedule.
   - ☐ Somewhat flexible; I can usually squeeze in extra appointments.
   - ☐ Not very flexible; I have a hard time escaping my very busy schedule.

3. *Which of the following is most important to you when it comes to teeth-straightening options and improving your smile?*
   - ☐ Low cost and/or flexible payment options.
   - ☐ Minimal impact on my career and personal life while I'm going through treatment.
   - ☐ A treatment plan that involves as little pain as possible.
   - ☐ No limitations on what I can eat while I'm going through treatment.
   - ☐ A treatment that makes it easy to keep my mouth clean and healthy.

4. *How do you feel about the spacing of your teeth? Are your teeth widely spaced with large gaps? Or are they more crowded?*

Crowded 4 2 0 2 4 Widely spaced

5. *Do you have more of an overbite or an underbite?*

Overbite 4 2 0 2 4 Underbite

For Office Use Only: _____