WELCOME

PATIENT INFORMATION

Name: ____ Sex: ☐ M ☐ F
Last First Middle Initial

Address:_______________________ City:______________ State:__________ Zip Code:____________

Birth Date:______________ Soc. Sec. #:______________ Email:______________________

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other

Home phone:______________ Cellular:______________ Other: ______________

Employer:_________________________________ Work Phone No:______________

Emergency Contact:_________________________________ Phone number: ______________

¿**Who may we thank for referring you to our office**?_________________________________

RESPONSIBLE PERSON (If different from patient)

Name of person responsible for this account: ______________________ Birth Date: ______________

Soc. Sec. #: ______________ Relationship to patient: ______________ Email: ______________

DENTAL INSURANCE

Insured Name: ______________________________ Relationship to patient: ______________

Soc. Sec. #: ______________ Birth Date: ______________ Employer: ______________

Insurance Company Name: ______________________________ Telephone: ______________

MEDICAL HISTORY

Physicians Name: ______________________ Telephone: ______________ Date of last visit: ______________

¿Have you had any serious illness or operations? ☐ Yes ☐ No If yes, describe: ______________________

¿Are you currently under physician care? ☐ Yes ☐ No Have you ever had a blood transfusion? ☐ Yes ☐ No

Women: ¿Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please circle Yes or No whether you have or had any of the following:

Yes / No Allergic to latex, metal, chemical

Yes / No	AIDS/HIV positive	Yes / No	Chemotherapy	Yes / No	Hemophilia/Abnormal bleeding		
Yes / No	Anaphylaxis	Yes / No	Circulatory treatments	Yes / No	Hepatitis	Yes / No	Pacemaker
Yes / No	Anemia	Yes / No	Cortisone treatments	Yes / No	Herpes	Yes / No	Psychiatric care
Yes / No	Arthritis, Rheumatism	Yes / No	Cough persistent	Yes / No	High blood pressure	Yes / No	Radiation treatment
Yes / No	Artificial Joints	Yes / No	Cough up blood	Yes / No	Jaw pain	Yes / No	Stroke
Yes / No	Artificial heart valves	Yes / No	Diabetes	Yes / No	Kidney disease/malfunction	Yes / No	Thyroids
Yes / No	Asthma	Yes / No	Epilepsy	Yes / No	Liver disease/malfunction	Yes / No	Tobacco habit
Yes / No	Atopic (allergy prone)	Yes / No	Glaucoma	Yes / No	Migraine	Yes / No	Tonsillitis
Yes / No	Back problems	Yes / No	Heart murmur	Yes / No	Mitral Valve Prolapses	Yes / No	Tuberculosis
Yes / No	Cancer	Yes / No	Heart problems/surgery	Yes / No	Nervous problems	Yes / No	Ulcers / Colitis

Other: ____

List of medications: ____

Any known allergies (ex. Penicillin)? Yes / No If yes, list all: ______________________

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used for the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical history, I will inform the dentist. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:_________________________________ Date: ______________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Notice to patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

____
Patient's Name (please print)

____________________________________ ____________________________
Patient's Signature Date

OR

____
Parent or Guardian's Signature

Please note: It is your right to refuse to sign this Acknowledgement

Dental Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our **Notice of Privacy Practices** by the patient noted above but it could not be obtained because:

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

____________________________________ ____________________________
Employee Signature Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state law.

FINANCIAL POLICY

Welcome to Smile Care Center!!!

Thank you for selecting our office for your dental care. We are committed to providing excellent dental care for our patients. The following information will acquaint you with our office financial policies.

- **INSURANCE BENEFITS:** We are happy to complete and submit your insurance forms on your behalf. Every effort will be made to collect the maximum benefits allowed by your insurance company. However, your insurance is a contract between you and your insurance company. We ask that you read your policy carefully. Some or all of the services we provide may not be covered by your insurance carrier. We will do our best to give you an accurate estimate, but we cannot guarantee the insurance payments in advance of submitting the claim. Any balances remaining, after your insurance pays, are due within ten (10) days of billing.

- **PAYMENTS:** Our policy is to collect FULL PAYMENT at the time of service. If insurance benefits apply, patients CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCE are due at the time of service unless arrangements have been made prior to the start of any treatment.

- **NO INSURANCE:** Patient will be 100% responsible for the services provided. The amount will need to be paid the day of the service unless arrangements have been made prior to the start of any treatment.

- **BALANCES:** Patients balances that go unpaid for 30 days or more may incur in the following charge: ***Interest charge of 1.5% per month***.

- **CHECKS:** There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF).

I, ______________________________________, certify that I have read and agreed to the policies of Smile Care Center.

____   __________________________

Patient, Parent, Guardian's Signature   Date

***VISA, Mastercard, Discover, American Express, Cash and Checks are accepted. ***

	APPOINTMENTS AND CANCELLATIONS / CITAS Y CANCELACIONES

Appointments and Cancellations

When we schedule your appointment, we are reserving a space for your particular needs. We ask that if you change an appointment, please give us at least **24 hours of notice**. This courtesy makes it possible to give your reserved space to another patient who would need it.

There is a charge for not calling or not showing up to your scheduled appointment of $35 dollars. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patients time is valuable. When your appointment is scheduled, a space is reserved, your records are prepared, and special instruments are ready for your visit. Except for emergency treatment of other patients, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

____________________	________________	____________________
Print name	Date	Signature

Citas y Cancelaciones

Cuando se programa su cita, se está reservando un espacio exclusivo para usted. Como paciente de Smile Care Center, es su responsabilidad asistir a sus citas en el tiempo estipulado. Si por alguna razón usted no puede asistir a su cita, le pedimos que por favor nos notifique con al menos **24 horas de anticipación**. Esta cortesía permite dar su espacio reservado a otro paciente que lo necesite.

Habrá un cargo de $35 dólares por no llamar o no presentarse a su cita programada. Las repetidas cancelaciones o las citas perdidas afectarán el privilegio de sus futuras citas.

Sentimos que el tiempo de nuestros pacientes es valioso. Cuando se programa su cita, se reserva un espacio, sus registros están preparados y los instrumentos especiales están listos para su visita. Con excepción al tratamiento de emergencia de otros pacientes, puedes esperar que seamos eficiente. Nosotros, por supuesto, agradeceremos la misma cortesía de su parte.

____________________	________________	____________________
Nombre completo	Fecha	Firma