Patient Registration

Last Name______________________ First Name______________ Middle Initial_____
Street Address____ Apt/Unit ________
City, State___________________________ Zip_________
Home Phone_________________ Cell Phone _________________ (***Text ok ?*** _______)
Email Address ____________________________ Primary Number to call first: _______

Birth Date _____/_____/______ Age ______ Sex______ Marital Status ____________
Social Security No._____-_____-_____

Occupation________________________Employer______________________________
Business Address____
Business Phone____________________________ Ext_______

Personal Information

Referred to us by____

In case of emergency, please contact:
Name_______________________________ Home Phone________________________
Address_____________________________ City/State___________________________
Relationship_________________________

Dental Insurance Information (if applicable)

Primary Carrier:
Ins. Co____
Employee Name____
Employer____
Group No_______________ Ins. ID # ______________________
Employee Social____-____-____ Employee Birth date____/____/____

Secondary Carrier:
Ins. Co____
Employee Name____
Employer ____
Group No_______________ Ins. ID # ______________________
Employee Social____-____-____ Employee Birth date____/____/____

Account Information

Person financially responsible for account: Self_____ Spouse_____ Other_____
If other than self, please complete the following information:

Name_________________________ Relation to Patient_______________________
Occupation____________________ Employer_______________________________
Business Address____
Business Phone________________________ Ext_______

Patient/Guardian Signature_________________________________ Date________________

Medical History Information **Guest Name: ___________________________________ Date of Birth: _____________**

Question	Yes	No
Have you been under the care of a medical doctor during the past two years? Physician's Name________________________ Address_________________________________ Phone__________________________________	Yes	No
Have you been a patient at the hospital during the past two years?	Yes	No
Have you taken any medication or drugs during the past two years?	Yes	No
Are you now taking any medication, drugs or pills, including aspirin? If yes, please list:	Yes	No
Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? If yes, please list:	Yes	No
Are you having pain or discomfort at this time?	Yes	No
Have you ever received intravenous (IV) bisphosphonates such as Zometa (Zoledronate) or Pamidronate (Aredia)?	Yes	No
Have you ever taken oral bisphosphonates such as Fosamax, Actonel or Boniva?	Yes	No

Indicate which of the following you have had or have at present. Circle "yes" or "no" next to each item.

Condition			Condition			Condition		
Heart Failure	Yes	No	Stroke	Yes	No	Have you seen a Acupuncturist?	Yes	No
Heart Disease or Attack	Yes	No	Artificial Joints	Yes	No	Have you seen a Chiropractor?	Yes	No
Angina Pectoris	Yes	No	Kidney Trouble	Yes	No	Have you seen a Neurologist?	Yes	No
Congenital Heart Disease	Yes	No	Ulcers	Yes	No	Have you seen an ENT?	Yes	No
Heart Murmur	Yes	No	Diabetes	Yes	No	Bite feels off	Yes	No
High Blood Pressure	Yes	No	Thyroid Problems	Yes	No	Neck/Back Pain	Yes	No
Arteriosclerosis	Yes	No	Glaucoma	Yes	No	Have you taken Prednisone?	Yes	No
Mitral Valve Prolapse	Yes	No	Cosmetic Surgery	Yes	No	Temporal Arteritis	Yes	No
Artificial Heart Valve	Yes	No	Emphysema	Yes	No	Facial Muscle Pain	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Over closed mouth	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	Ringing in ears	Yes	No
Rheumatic Fever	Yes	No	Allergies or Hives	Yes	No	Fainting or Dizzy Spells	Yes	No
Arthritis	Yes	No	Epilepsy or Seizures	Yes	No	Nervousness	Yes	No
Rheumatoid Arthritis	Yes	No	Radiation Therapy	Yes	No	History of Depression	Yes	No
Yellow Jaundice	Yes	No	Chemotherapy	Yes	No	Headaches/ Migraines	Yes	No
Cortisone Medicine	Yes	No	Hepatitis A (infectious)	Yes	No	Jaw Popping	Yes	No
Drug Addiction	Yes	No	Hepatitis B (serum)	Yes	No	Limited Opening	Yes	No
Smoker	Yes	No	Hist. of Cancer/Tumor	Yes	No	Sinus Trouble	Yes	No
Liver Disease	Yes	No	Bruise Easily	Yes	No	Pain in Jaw Joints	Yes	No
Sickle Cell Disease	Yes	No	Hemophilia	Yes	No	Obstructive Sleep Disorder	Yes	No
Anemia	Yes	No	Blood Transfusion	Yes	No	Insomnia	Yes	No
A.I.D.S./ H.I.V. Positive	Yes	No	Venereal Disease	Yes	No	Sleep Apnea	Yes	No
						Snoring	Yes	No

Question	Yes	No
Do you have or ever had any disease, condition, or problem not listed? (If yes please list separately)	Yes	No
Do you use more than two pillows to sleep?	Yes	No
Do you ever wake up from sleep and feel short of breath?	Yes	No
Do your ankles swell during the day?	Yes	No
If you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?	Yes	No
Are you on a special diet?	Yes	No
Have you lost or gained more than 10 pounds in the past year?	Yes	No

Women Only: Are you pregnant? **Yes, __ No** What month due? ______

Are you nursing? **Yes No** Are you taking birth control pills? **Yes No**

I find the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions all questions truthfully and to the best of my knowledge.

Consent for examination (only)

The undersigned hereby authorizes Doctor to take X-rays, study models, photos, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for all services provided in this office for me or my dependents is mine, due and payable at the time services are rendered unless written and signed financial arrangement has been made. I further understand that any insurance reimbursement is my responsibility and that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (We) agree to pay legal interest on the indebtedness, together with such collection costs (no less than $50) and reasonable attorney fees as may be required to effect collection of this note.

Print Name_______________________________________ Sign ____

Date_________________________ Dr. Signature ____

Dental History Date _____________

Guest Name ______________________ Preferred Name_____________ Date of Birth _________

Work/ Retired from ____
Hobbies ____

What if any problems are you having right now?
____
Sensitivity: Yes / No Hot Cold Bite Sweets Other ________________________

When was your last dental visit? _______________ What was done? _____________
How would you rate the health of your teeth and gums on a scale of **1 to 10**? _______
Are you able to eat everything you want? Yes / No ___________________________
What is most important to you about your teeth? ______________________________
How would you rate how happy you are with your smile on a scale of **1 to 10**? ______
Are you ever self-conscious about your smile? Yes / No
What about your teeth/smile is not as nice as you would like it to be?
____
If you could have your mouth any way you want it, what would it be like?
____
Do you have any concerns about your old metal / mercury fillings? Yes / No
Have you been told you have gum disease or pyorrhea? Yes / No
What kind of gum treatment have you had in the past?
____

How do you take care of your teeth? ____Manual Brush ____Electric Brush ____Floss
____ Irrigator ____ Tongue Cleaner ____ Rinse

Do you have bleeding when you brush or floss? Yes / No

Does food get caught between your teeth? Yes / No

Do your jaws ever: Pop Noise Pain Lock Open Lock Close None

Are you aware of clenching during the day or grinding at night? Yes / No

Have you ever been told you grind your teeth at night? Yes / No

Do you have a bite guard? Yes / No Use it when? ______________________________

Have you ever had sedation for your dental treatment? Yes / No

Is there anything else we could do or not do to make your visits absolutely perfect?
____
Is there anything that would prevent you from having treatment now?
____

Would longer appointments work better for you if it meant fewer visits? Yes / No

Have you given any thought as to a lifetime budget for your dentistry?
____

<u>HIPAA Acknowledgement</u>

ACKNOWLEDGEMENT OF RECEIPT OF OUR ADHERENCE TO STATE AND FEDERAL PATIENT PRIVACY PRACTICES

Please be advised that THE SMILE CENTRE will only use your personal & health information that is retained in your patient chart for professional, (doctor-to-doctor type) communications. We will file insurance information electronically and/or via U.S. mail within the same privacy guidelines.

Do we have your permission to:

Send appointment reminders to your home/e-mail: ***Yes*** ____ ***No*** ____

Leave the following information on your home or cell answering machine/ voice mail:

Appointment Information ***Yes*** ____ ***No*** ____
Billing Information ***Yes*** ____ ***No*** ____

Leave the following information on your work answering machine/ voicemail:

Appointment Information ***Yes*** ____ ***No*** ____
Billing Information ***Yes*** ____ ***No*** ____

I give permission to share <u>appointment</u> information with the person named below:

Name: ____

I give permission to share <u>billing</u> information with the person named below:

Name: ____

The undersigned acknowledges receipt of the current Notice of Privacy Practices at The Smile Centre, P.A.

Date: ________________

Please Sign Name: ____

Please Print Name: ____

Thank you. If you have any questions about this form or about our complete Privacy Policy, please contact our privacy policy officer, Tricia Stanley, Administrator.

Signature of Smile Centre Representative:______________________________

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

THE SMILE CENTRE, PA

AUTHORIZATION:
By my signature below, I affirm, as a patient of The Smile Centre OR as a parent or legal guardian of a minor child that is a patient of The Smile Centre (the "Patient"), that I authorize The Smile Centre: (i) to capture photographic or video images of the Patient (the "Images"); (ii) to reproduce, use, disclose the Images, with or without the Patient's name; (iii) to publicize the fact that dental services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding The Smile Centre (collectively referred to herein as the "Information"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of The Smile Centre. The authorization is given to The Smile Centre listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

PURPOSE:
The purpose of this authorization is to permit the Information, including Images, to be used for marketing of The Smile Centre, and I explicitly consent to the use of Information for advertising and marketing activities to promote The Smile Centre. I acknowledge and agree that no compensation will be provided for the use of the Information.

EXPIRATION AND REVOCABILITY:
If Patient is signing on his or her own behalf, this authorization expires when the Patient informs The Smile Centre that he or she is no longer a patient of The Smile Centre. If Patient is signing on half of a minor child, this authorization expires when the Paitent reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying The Smile Centre by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by The Smile Centre. Upon receipt of the notice of revocation, The Smile Centre will make reasonable efforts to remove protected health information from social media platforms over which it has control, but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that The Smile Centre cannot control all re-disclosure of information.

NO EFFECT ON TREATMENT:
This authorization is voluntary. I understand that The Smile Centre cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

NAME OF PATIENT (PRINTED): ______________________________ DATE OF BIRTH __________

SIGNATURE OF PATIENT OR PARENT/ GUARDIAN (IF SIGNING FOR MINOR):

____ DATE: ________________

PRINTED NAME OF PARENT OR GUARDIAN (IF SIGNING ON BEHALF OF MINOR):

____

Sarasota, University Pkwy: (941) 351-4468
South Tamiami Trail (941) 366-3636
Venice (941) 497-5451

Financial Policy

Thank you for choosing The Smile Centre. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Our office accepts:

- Cash or check, Visa®, MasterCard®, American Express® or Discover Card®
- Special financing options with convenient monthly payments available with the Care Credit healthcare credit card, Wells Fargo Health Advantage Card, Lending Club Patient Solutions[1]
  - Allow you to pay over time
  - Interest Deferred or Low interest options

Please note:

If you choose to discontinue care before treatment is complete, your refund, if any, will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans requiring appointments of 1 ½ hours or more, a 50% deposit is required to secure your initial treatment appointment. For appointments 3 hours or longer 100% pre-pay is required.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly submit your claims for your treatment.[2]

A fee of $35.00 is charged for patients who miss or cancel more than 1 time in a calendar year without 48-hour notice.

The Smile Centre charges $40 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]CareCredit, Wells Fargo Health Advantage and Lending Club are NOT in-house credit programs offered by The Smile Centre or any other healthcare provider. You may apply for the credit, and if approved; use it at The Smile Centre's offices. However, the financial agreement is between you and the bank used by these lenders. Subject to credit approval.

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.