OC Lifesmiles
PROGRESSIVE DENTISTRY

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Work: _____ Cell: _____

☐ *By providing my phone number, I consent to receive SMS text messages from [location name] for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply HELP for support. Reply STOP to opt out. Please check our privacy policy and terms and conditions for details.*

Email Address: _____

Address: _____
Street Apartment #

_____
City State ZIP Code

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

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Work: _____ 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: _____ 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: _____

_____

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

Are you taking any medications? ☐ Yes ☐ No
If yes, please explain: _____

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: _____

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

Have you ever had a local anesthetic? ☐ Yes ☐ No

Have you ever had an unfavorable reaction from a local anesthetic? ☐ Yes ☐ No

Have you ever had serious trouble associated with previous dental treatment? ☐ Yes ☐ No

How long since your last full mouth x-rays? _____

Have you been treated with Orthodontics in the past? ☐ Yes ☐ No If yes, has it relapsed? ☐ Yes ☐ No

Health Information Continued

Do you want straighter teeth? ☐ Yes ☐ No

Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No

If you could have your teeth whitened, would you be interested? ☐ Yes ☐ No

Would you be interested in sleep dentistry? ☐ Yes ☐ No

Is there anything else about having dental treatment that bothers you? ☐ 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 changes in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

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 1 ½% 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 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.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use your photos for demonstration purposes. **Patient Rights:** You have a right to look at or get copies of your health information, with limited exceptions. 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.

Name _____ Date: _____ Relationship to Patient: _____

Office Protocols

FINANCIAL PROTOCOL

In the interest of good dental care practice; it is desirable to establish a debit protocol to avoid misunderstandings. Our primary responsibility is to help our patients experience good dental health and we wish to spend our time and energy toward that end. To assist our patients, we offer the following methods for taking care of their account at our office:

*We accept credit cards (Visa, Mastercard, Discover, American Express)

*As a courtesy we will gladly bill your insurance when you provide us with the current information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the charges which is expected at the time of service. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. You are ultimately responsible for payment of your account.

*For patients who qualify, we offer various payment plans through CareCredit a GE Company. They offer numerous payment options that will fit comfortably in almost any monthly budget. CareCredit offers a line of credit that can be used by the whole family for ongoing treatments without having to reapply. There are no upfront costs, pre-payment penalties, or annual fees to our patients.

MISSED OR CANCELED APPOINTMENTS

We kindly ask that patients give us 48 hours notice, if they are unable to keep an appointment. There will be a charge for failed appointments.

ESTIMATES AND FEES

After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is required to pay for dental services when they are rendered.

OUTSTANDING ACCOUNTS

There is a 1.5% finance charge (18% APR) on any unpaid balance carried for more than sixty days. Delinquent accounts over 90 days will be turned over to a Credit Reporting Collection Agency. In addition to these collections agency expenses, delinquent accounts are also liable for attorney fees and court costs associated with the collection of debt.

Please let us know if you have any questions or concerns about any of our office protocols.

Patient or Responsible Party Signature: _____

Date: _____