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Date: _____ **Patient Name:** _____

Date of Birth: _____ **SS #** _____ **Male** ____ **Female** ____

Marital Status: ____Single ____Married ____Separated ____Divorced ____Widowed

Home Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Mailing Address if Different from Home: _____

Home # _____**Cell #** _____**Work #** _____**Email:** _____

If patient is a minor, who is legally responsible? _____ **Relationship** _____ **Cell #** _____

In case of Emergency, who should we contact?
_____

Emergency # _____ **Relationship:** _____

Who may we Thank for your referral: _____

How did you hear about us: ____ **Internet** ____**Brochure** ____ **Other** _____**Post Card**_____

Insurance Information:

Do you have Insurance for us to bill for you today: ____**Yes** ____ **No**

Subscribers Employer: _____ **Phone:**
_____

Name of Insurance Co: _____ **Phone:**
_____

Insurance Address: _____

Subscribers Name: _____ **Date of Birth:** _____ **SS#** _____

Group # _____ **Subscribers ID #** _____ **Relationship to Subscriber:** _____

Does patient have additional insurance? ____ **Yes** _____ **No**

Subscribers Employer: _____ **Phone:**
_____

Name of Insurance Co: _____ **Phone:**
_____

Insurance Address: _____

Subscribers Name: _____ **Date of Birth:** _____ **SS#** _____

Group # _____ **Subscribers ID #** _____ **Relationship to Subscriber:** _____

**** I hereby authorize payment of the dental and insurance benefits and authorize the release of dental information to my insurance company in order for claims to be processed. I hereby consent to treatment. I have received and signed the financial policy.**

Patient or Guardian Signature **Date**

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Patient Name: _____ **Date:** _____

Are you under medical treatment now? I so, please explain _____

Treating Physician: _____ Phone # _____

Have you ever been hospitalized for any surgery or serious illnesses? _____ Yes _____ No

Have you ever taken any Bisphosphonate drugs such as Fosamax, Actonel, Boniva, or Reclast? ___Yes ___ No

Have you ever taken Fen-Phen ___Yes ___ No **Do you need to Premed** **___ Yes ____ No**

MEDICAL CONDITIONS

__ Heart Attack/Surgery	__ Hepatitis/Jaundice	__ Arthritis	__ Heart Murmur
__ Kidney Disease	__ Glaucoma	__ Diabetes	__ Heart Disease/Pacemaker
__ Fainting	__ Chest Pains	__ Thyroid Problems	__ Epilepsy/Convulsions
__ High/Low Blood Pressure	__ Stomach Problems	__ HIV Infection/Aids	__ Rheumatic Fever
__ Leukemia/Anemia/Blood Disorder		__ Stroke	__ Herpes Simplex I or II
__ Drug/Alcohol Abuse	__Tuberculosis	__ Cancer	__ Radiation/Chemotherapy
__ Asthma/Respiratory	__ Hay Fever/Allergies	__Full/Partial Joint Replacement	

__ Other, Please Explain _____

Women Only: Are you Pregnant? __ Yes __ No Are you taking birth control? __ Yes __ No

ALLERGIES

__ Aspirin/Ibuprofen	__ Penicillin	__Sulfa
__ Codeine	__ Sedative	__ Iodine
__ Latex	__ Local Anesthetic	
__ Other _____		

LIST MEDICATIONS

_____

_____

_____

_____

PATIENT DENTAL HISTORY

When was your last dental visit ? _____

Name of previous Dentist? _____ When were X-Rays last taken? _____

Yes __ No __ Are you having pain/discomfort as this time?

Yes __ No __ Have you had any problems with your Jaw?

Yes __ No __ Do your gums bleed when you brush?

Yes __ No __ Do you clench or grind your teeth?

Yes __ No __ Do you have a history of gum disease?

Yes __ No __ Use Tobacco products?

Yes __ No __ Are you aware of any lumps in your mouth?

Yes __ No __ Have you ever had a bad experience in a dental office in the past?**

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 may be detrimental to my health.

_____

Patient /Guardian Signature **Date**

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

(Please check one of the following)

**** I have received a copy of this offices notice of Privacy Practices** _____

**** I have reviewed the notice of Privacy Practices, but declined my copy** _____

Print Name

Signature **Date**

Relationship to Patient

For office use only

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communication barriers prohibited obtaining acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgment**
- **Other (please specify)** _____

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Financial Policy

Thank you for choosing *Ten Mile Smiles* as your dental care provider! Our professional dental team is committed to providing you excellent dental care in a friendly, comfortable setting. The following is a statement of our financial policy, which we request that you read and sign prior to treatment.

Full payment is due at the time of service. We accept cash, check, debit card, Visa, MasterCard, Discover, American Express and Care Credit. Interest on balance unpaid beyond 90 days will be applied at the rate of 1.5% monthly (18% annually). While we do accept assignment of insurance benefits, your portion of each service is due at the time services are rendered. This may be based on an estimate of insurance payment.

Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. We do, however, submit dental claims as a courtesy to our patients and will do our best to assist you in understanding and applying your dental benefits. We cannot guarantee insurance payments or payment amounts. It is our recommendation, that you are knowledgeable and understand your policy. All treatment estimates are provided based upon information from your insurance company and are **estimates only**. If your insurance company has not paid your account in full within 90 days of billing, we will require the balance to be paid directly by you via cash, check, debit or credit cards.

Treatment plan are created based upon clinical findings during your diagnostic exam and are subject to change based upon clinical need and/or our treatment schedule.

Our policy is to charge for missed appointments or appointments that are not cancelled less than a 24 hour notice at the rate of $25.00 per appointment. Please help us serve you better by keeping scheduled appointments. **Last min cancellations are disruptive to everyone's schedules**. **Please be considerate** 😊

Return checks are subject to an additional fee of $25.00. Unpaid balances are subject to action by a collection agency.

Signature on File

By signing below, I give my permission for Ten Mile Smiles to release necessary information regarding my treatment to by insurance company(s) and assign dental benefit payments directly to *Ten Mile Smiles*.

If you have any further questions regarding our financial policy, please ask a member of our dental team.

I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

Print Name: _____ Date: _____

Signature: _____