Radiant Smiles Family Dental, PLLC

We are complimented that you have selected us to provide dental care for you and your family. Whom may we thank for referring you to our office? _____

Patient Information

Patient's Name Last _____ First _____ MI _____ Date of Birth _____/_____/_____

Address Street _____ City _____ State _____ Zip _____

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

Email Address _____ Social Security # _____-____-_____

Gender ☐ M ☐ F Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partnership

Employer/ School _____ Occupation _____

If patient is a minor, give parent's/guardian's name_____

Emergency contact _____ Relationship _____ Phone number (_____) _____

Who is responsible for your account and payment, if different from above? ☐ N/A

Name Last _____ First _____ MI _____ Relationship to patient _____

Address Street _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Social Security # _____-____-_____

Primary Dental Insurance Information

Insurance Company _____ Phone (_____) _____ Group # _____ ID# _____

Subscriber's name _____ Subscriber's Social Security # _____-____-_____

Date of Birth _____/_____/_____ Relationship to patient _____

Employer offering this insurance _____ Phone number (_____) _____

Secondary Insurance Information

If you have dual coverage, please fill out the following:

Subscriber's Name _____ Phone (_____) _____

Social Security # _____-____-_____ Date of Birth _____/_____/_____ Relationship to patient _____

Insurance Company _____ Phone (_____) _____ Group # _____ ID# _____

Employer offering this insurance _____ Phone number (_____) _____

Payment Responsibility

*For our patients without dental insurance.....*I understand that all responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

*For our patients with dental insurance.....*I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately responsible for payment of all dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office. If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all collection costs.

I understand that it is my responsibility to advise your office of any changes in the information on this form.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

PATIENT NAME _____ **DATE** _____

Dental History

Reason for today's visit _____

Date of last dental visit _____ Name of previous dentist _____

Reason for leaving your last dentist ☐ Unsatisfied ☐ Inconvenience (schedule or location) ☐ Insurance ☐ Moved ☐ Other _____

Please check any of the following that apply:

☐ I have bad breath
☐ My gums bleed when I brush
☐ I have had periodontal treatment (deep cleaning) in the past
☐ My teeth are very sensitive (to cold, hot or sweet; when biting)
☐ I grind my teeth or I have been told I do
☐ I smoke/ used to smoke tobacco products, how often _____
☐ I get food caught in between the same teeth over and over
☐ I have loose teeth or broken fillings/teeth
☐ I don't like my smile
☐ I have missing teeth and I would like to restore the spaces
☐ My jaw clicks, pops or I currently have or have bad jaw joint pain
☐ I have sores or growth in my mouth

How often do you floss? _____ How often do you brush? _____

Please share with us any past positive or negative experience in a dental office, so we can better serve you. _____

Medical History

Primary care physician's name _____ Date of last visit _____

Are you currently under the care of a physician for a chronic disease or condition? ☐ No ☐ Yes, for what condition(s)_____

Have you ever been hospitalized or had a major operation? ☐ No ☐ Yes, date and nature of surgery? _____

Have you ever had a serious injury to your head or neck? ☐ No ☐ Yes, date and nature of injury? _____

Have you ever taken Fen-Phen, or bisphosphonates (Boniva, Fosamax, Zometa, Prolia, etc.)? ☐ No ☐ Yes _____

Have you ever undergone radiation therapy for any reason? ☐ No ☐ Yes, date and area of radiation _____

Are you allergic to ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other_____

WOMEN (please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Please list medications you are currently taking, including dosages, if known.

Medication	Dosage	Condition

Do you have, or have you had, any of the following conditions?

☐ Anemia
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ AIDS
☐ Alzheimer's Disease
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Cold Sores
☐ Congenital Heart Disorder
☐ Diabetes (DM I or II)
☐ Drug Addiction
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Genital Herpes
☐ Glaucoma
☐ Gastric Reflux (GERD)
☐ Heart Attack/Failure
☐ Heart Disease
☐ Heart Murmur
☐ Heart Pacemaker
☐ Hepatitis (A, B or C)
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ HIV Positive
☐ Hypoglycemia
☐ Irregular Heart Beat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Lung Disease
☐ Low Blood Pressure
☐ Psychiatric Condition
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sinus Trouble
☐ Snoring / Sleep Apnea
☐ Stroke
☐ Seasonal allergies
☐ Shortness of Breath
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers

Have you ever had any other serious illness not checked above? ☐No ☐ Yes _____

Do you wish to talk to the dentist privately about any problem? ☐ No ☐ Yes _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____ **Date** _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ **Date** _____

For Admin Only

Ref _____ **E/O** _____

Ins Hx - FMX _____ **Perio** _____ **Notes** _____

INSURANCE AND FINANCIAL POLICY

At Radiant Smiles Family Dental, PLLC, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Here are some important things you should know:

If you have dental benefits, your benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for all of your dental care expenses. It is only meant to assist you.**

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but **it is only an estimate**. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

We bill your insurance as a courtesy. If insurance does not pay within 90 days, Radiant Smiles Family Dental, PLLC reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot, be a part of that legal contract. Ultimately, you are responsible for all expenses for the dental care we provide and all costs we incur to collect.

We require payment in full for your portion at the time of service, or we may request your estimated portion to be paid in full prior to reserving an appointment time. We accept MasterCard, Visa, American Express, Discover, and cash. We do not accept personal checks. If you are in need of an extended finance option, we also work with CareCredit, offering "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of the staff for an application.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, **we require at least 24 hours notice to avoid a $50/hour cancellation fee** (emergencies are an exception).

We welcome you to our family and look forward to helping you with your dental needs. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Agreement: ***The undersigned acknowledges he/she has read all of the above, understands what it says, and agrees to pay to Radiant Smiles Family Dental, PLLC all amounts charged by Radiant Smiles Family Dental, PLLC for dental services provided to me and not reimbursed by any insurance, plus if necessary any and all collection costs.***

Patient Signature _____ Date _____

GENERAL CONSENT TO TREATMENT

1. I hereby authorize and direct the dentist(s) of Radiant Smiles Family Dental, PLLC and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, (x-rays), or diagnostic aids:

   A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
   B. Application of plastic sealants to the grooves of the teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
   D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
   E. Removal (extractions) of one or more teeth.
   F. Treatment of diseased or injured oral tissues (hard and/or soft).
   G. Treatment of malpositioned (crooked) teeth and/or oral development or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints and/or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well-being in the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctor(s) to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient name: _____

Patient signature: _____ Date: _____

Name of parent or guardian: _____

Relationship to patient: _____

Parent or guardian signature: _____

Witness signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name_____

Signature_____

Date_____

****************************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
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please specify)
  _____
  _____

X-RAY POLICY

At Radiant Smiles Family Dental, PLLC, your dental health is our priority! To make an appropriate dental diagnosis, adequate x-rays must be taken of your teeth and surrounding structures. We adhere to the following protocol to maintain quality of care:

- All new patient comprehensive exams will require a **Full Mouth Series (FMX)** of x-rays. An FMX, consisting of 18 films, provides a detailed view of the teeth, their roots, and the surrounding bony structures, and is taken every 3-5 years.

- Existing patients will require a minimum of four (4) **Bitewing** or "check-up" x-rays each year for up to 3-5 years following an FMX. Periodontal conditions, extent of existing dental work, and other factors may necessitate the need for an FMX or additional x-rays on a more regular basis.

- X-rays taken prior to your initial visit may be used to satisfy the need for required x-rays at our office. As a courtesy our staff will be happy to assist you in obtaining copies of prior x-rays.

Please note that required x-rays must be taken in order to continue treatment with us, regardless of your insurance coverage. **It is a violation of state law to treat a patient without adequate x-rays.** State law also dictates that a patient cannot consent to negligent treatment. Therefore, refusal of necessary x-rays will constitute termination of the doctor-patient relationship.

We appreciate your understanding of this policy. Staff members will be happy to answer any questions you may have.