SMILES ON BELMONT
Family & Cosmetic Dentistry

PATIENT INFORMATION

Name: (First)_____(MI)_____(Last)_____ Preferred name: _____

Birth Date (MM/DD/YYYY) _____ Age: _____ Gender: M / F / X SSN: _____

Address: _____ (City) _____ (State)_____ (Zip) _____

Phone: (_____)-_____ Email: _____

Occupation: _____ Employer: _____

Emergency Contact: Name: _____ Relationship: _____Phone: (_____)-_____

How did you find out about Smiles on Belmont? _____

FINANCIAL INFORMATION IF DIFFERENT THAN ABOVE

Name: _____ Birthdate:_____ SSN:_____

Phone: _____Employer:_____ Occupation: _____

PARENT/GUARDIAN (IF PATIENT IS A MINOR)

Name: _____ Birth Date: _____ SSN:_____

Phone: _____Employer:_____ Occupation: _____

MEDICAL RELEASE

I hereby authorize Smiles on Belmont to release my protected health information including financial information to the following individuals:

Name(s) of Individual(s): _____

STATEMENT OF AUTHORIZATION

I certify that I am the patient or legal guardian listed above, have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of my protected health information by Smiles on Belmont for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for general healthcare operations. I hereby authorize Smiles on Belmont to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement or charges incurred during the course of treatment. I understand I have a right to review Smiles on Belmont's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and Smiles on Belmont's duties regarding the types of uses and disclosures of my Protected Health Information.

By signing this application, I affirm that I understand and agree to this statement of authorization.

_____ _____

Signature of Patient or Personal Representative Date

INFORMED CONSENT

I hereby consent to the performance of examinations and dental procedures by Dr. Cody Charron, DMD and his staff that are deemed necessary or advisable in the diagnosis and treatment of dental conditions. I understand I can at any time ask questions and discuss with Dr. Cody Charron and/or with other clinic personnel the nature and purpose of such dental procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of dentistry carries some risks to treatment. I do not expect the physician to be able to anticipate and explain all risks and complications.

I have read, or have had read to me, the above consent and by signing below, I agree to procedures and treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

_____ _____

Signature of Patient or Personal Representative Date

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MEDICAL HISTORY

Although dental care primarily focuses on the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important effect on your dental health. Thank you for answering the following:

Are you under a physician's care now?	O Yes	O No	If yes_____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes_____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes_____
Are you taking any medications, pills or drugs?	O Yes	O No	If yes_____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	If yes_____
Have you ever taken Fosamax, Boniva, Actonel or any	O Yes	O No	If yes_____
Have you ever taken Fosamax, Boniva, Actonel or any Other medications containing bisphosphonates?	O Yes	O No	If yes_____
Are you on a special diet?	O Yes	O No	If yes_____
Do you use tobacco?	O Yes	O No	If yes_____

Are you pregnant/ trying to get pregnant? O Yes O No Nursing O Yes O No Taking oral contraceptives? O Yes O No

Are you allergic to any of the following?

☐ Penicillin ☐ Sulfa Drugs ☐ Sulfites ☐ Erythromycin ☐ Iodine ☐ Local Anesthetics ☐ Benzocaine

☐ Other: _____

Do you use controlled substances? O Yes O No If yes please list: _____

Please select any of the following you have ever had:

☐ AIDS/HIV positive	☐ Diabetes	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Drug Addiction	☐ Herpes	☐ Rheumatism
☐ Anaphylaxis	☐ Easily winded	☐ High Blood Pressure	☐ Scarlet Fever
☐ Anemia	☐ Emphysema	☐ High Cholesterol	☐ Shingles
☐ Angina	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Artificial Joint	☐ Fainting Spells	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Disease	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Breathing Problems	☐ Genital Herpes	☐ Lung Disease	☐ Tonsillitis
☐ Bruise Easily	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Hay Fever	☐ Osteoporosis	☐ Tumors or Growths
☐ Chemotherapy	☐ Heart Attack/Failure	☐ Pain in Jaw Joints	☐ Ulcers
☐ Chest Pains	☐ Heart Murmur	☐ Parathyroid	☐ Venereal Disease
☐ Cold Sores	☐ Heart Pacemaker	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Congenital Heart	☐ Heart Issues	☐ Radiation	
☐ Convulsions	☐ Hemophilia	☐ Recent Weight Loss	
☐ Cortisone Meds	☐ Hepatitis A	☐ Renal Dialysis	

Have you ever had a serious illness not listed above? O Yes O No If yes_____

DENTAL HISTORY

Previous Dentist_____			Date of Last exam_____		
Date of last X-Rays_____			When were your teeth cleaned last? _____		
How often do you brush your teeth? _____			How often do you floss your teeth? _____		
Do your gums bleed while Brushing or flossing?	O Yes	O No	Do you use chewing tobacco?	O Yes	O No
Do you have sore teeth?	O Yes	O No	Are you nervous about dental treatment?	O Yes	O No
Have you been treated for gum disease?	O Yes	O No	Do you clench your jaw or grind your teeth?	O Yes	O No
Have you had orthodontic treatment (Braces) ?	O Yes	O No	Have you ever experienced pain/ discomfort?	O Yes	O No
Do you have dry mouth?	O Yes	O No	Popping in your jaw joint (TMJ)?	O Yes	O No
Do you smoke?	O Yes	O No	Do you have any swelling or lumps in your mouth?	O Yes	O No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my dependent's health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient or Personal Representative Date

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FINANCIAL POLICY

Thank you for choosing Smiles on Belmont. We are committed to giving you the best possible dental care and want you to feel comfortable throughout your treatment. This includes understanding your treatment plan as well as our financial policy.

After the initial x-rays and examination, we will provide you with a cost estimate for any recommended treatment. At that time financial arrangements will be made before treatment is rendered.

Insurance Coverage

We currently work with several dental benefit plans. As a courtesy we will bill your insurance company directly, however the responsibility for payment remains with you. The amount of coverage that your plan provides is negotiated between your employer and the insurance company. Coverage may be limited by what the insurance company calls the "usual, customary and reasonable" (UCR) fees. These are ceilings on the fees for dental procedures set by the insurance company, at which point the benefit plan will stop reimbursement. There may be a difference between our fees and the UCR fees because the UCR fees were often determined many years ago and are seldom relevant to quality dentistry in today's market. Any difference between the two fees is the responsibility of you, the patient.

Although we maintain computerized histories of payment by several companies, payment of benefits is never guaranteed by insurance companies. Therefore, it is impossible to give you a guaranteed quote price at the time of service. We estimate your portion based on the most up-to-date information we have, but it is still only an estimate.

Please keep in mind that a dental plan is a contract between you, the patient, your employer, and the insurance company. Therefore, you are ultimately responsible for all charges regardless of dental benefits.

Financial Options

Payment is due at the time of service. We offer a 5% discount for cash or check at the time of service for amounts over $100. We accept all major credit cards, Care Credit upon approval, and offer some extended payment plans for amounts over $500.

Financial Charges

All past due balances (90 days and greater) are subject to finance charges of 18% APR.

A fee of $250 will be charged to any account turned over to collection agency.

Cancelled or Missed Appointment Fee

A fee is charged for appointments missed or cancelled with less than 24 hrs notice. Your appointment time is reserved for you and without advance notice, we are unable to make use of missed appointment time.

I understand that I am responsible for all costs of dental treatment. I have read and fully understand the financial policies of this dental office. I hereby authorize all dental insurance benefits to be paid directly to Smiles on Belmont LLC.

_____ _____

Signature of Patient or Personal Representative Date