Belleair Smiles

Welcome to Belleiar Smiles – Tell Us about Yourself

Name _____(Circle) Male Female
Last First MI Preferred

Address_____ Apt_____City_____ State _____ Zip _____

SSN _____-_____-_____ DOB _____ E-mail _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Marital Status (Circle) Single Married Divorced Widowed Separated Domestic Partner

How did you hear about our office?_____

How do you prefer to be contacted for appointment confirmation? (circle preference) Phone E-mail

Nearest relative not living with you _____ Phone # _____

Insurance – Subscriber Information

Name _____ Relationship _____ DOB _____

SSN/ID_____ Employer _____Group Number_____

Insurance Company Name_____ Phone Number _____

Address_____City_____ State_____ Zip _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Belleair Smiles all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the used of this signature on all insurance submissions.

Responsibility Party Signature _____ Relationship _____ Date _____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

_____
Patient Signature (or legal guardian)

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Medical History

Patient Name _____

Are you currently under the care of a physician? Yes No Date of last visit _____

Physician's name_____ Physician's phone number _____

Your current physical health is: Good Fair Poor Do you use tobacco in any form? Yes No

Have you ever had any metal rods, pins, or implants placed? Yes No Where_____

Are you taking any medications? Yes No Please list each medication: _____

_____

Have you ever had any surgical procedures? Yes No Please list each procedure:_____

_____

Check Yes or No for Each Condition Listed

Condition	Yes	No
Abnormal Bleeding		
Alcohol Abuse		
Allergies – Seasonal		
Anemia		
Angina Pectoris		
Arthritis		
Artificial Heart Valve		
Asthma		
Blood Transfusion		
Cancer		
Chemotherapy		
Colitis		
Congenital Heart Defect		
Diabetes		
Difficulty Breathing		
Drug Abuse		
Emphysema		
Epilepsy		
Facial Surgery		
Fainting Spells		
Fever Blisters		
Frequent Headaches		

Condition	Yes	No
Glaucoma		
HIV-AIDS		
Heart Attack		
Heart Murmur		
Heart Surgery		
Hemophilia		
Hepatitis A		
Hepatitis B		
Hepatitis C		
High Blood Pressure		
Joint Replacement		
Kidney Problems		
Liver Disease		
Low Blood Pressure		
Mitral Valve Prolapse		
Pace Maker		
Psychiatric Problems		
Radiation Therapy		
Rheumatic Fever		
STD		
Seizures		
Shingles		

Condition	Yes	No
Sickle Cell Disease		
Sinus Problems		
Stroke		
Thyroid Problems		
Tuberculosis		
Ulcers		
Allergies to:	**Yes**	**No**
Codeine		
Dental Anesthetics		
Erythromycin		
Jewelry		
Latex		
Metal		
Penicillin		
Tetracycline		
Sulfa		
If Female, please answer	**Yes**	**No**
Taking birth control pills?		
Pregnant? # weeks_____		
Nursing?		

I certify that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature_____ Date_____

Reviewed by _____ Date_____

Belleair Smiles

Dental History

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No Where? _____

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) Yes No

Are you under stress? (new job, moving, relationship) Yes No

Do you like your smile? Yes No

What would you like to change about your smile? _____

Are you happy with the color of your teeth? Yes No

Do your gums bleed? Yes No

How many times a day do you brush? _____ How many times per week do you floss? _____

Are your teeth sensitive to heat, cold, or anything else? Yes No

Have you lost any teeth? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last dental visit? _____

When was your last professional dental cleaning? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visits? _____

Here at Belleair Smiles we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your appointment.

Tooth Whitening	Veneers/Lumineers	Invisible Braces
Partials/Dentures	Smile Makeover	Bonding
Sealants	Crown & Bridge	Implants/Implant Crowns
Night/Sport Guards	Replacing Missing Teeth	

Belleair Smiles

HIPAA Consent

I, _____ hereby authorize Belleair Smiles to use and disclose in any form or format a copy of my dental records and/or x-rays to other dentists as required or requested. A photo or electronic copy of this signed, dated authorization shall be as effective as the original.

Belleiar Smiles may use and disclose any protected health information to my dental or health insurance provider for the purpose of filing dental or medical claims and/or my physician or health care specialist for the purpose of obtaining medical clearance or information for surgery.

I have been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

The undersigned does hereby release, hold harmless, and agree to indemnify Belleair Smiles, its employees, and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until the practice is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that Belleair Smiles has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization.

Print Name_____ Date_____

Signature_____ Date_____

OR -- Patient's Representative

Print Name_____ Date_____

Describe Authority _____

Signature_____ Date_____

Belleair Smiles

Financial Policy

Belleair Smiles requires all patients to make financial arrangements with us before we provide treatment. By signing this policy, you are affirming that you have read, understand, and agree to the following statements:

1. I understand that payment in full is due at the time of service for me and any party for whom I am financially responsible.
1. I understand that Belleair Smiles will maintain a copy of my government-issued photo identification (driver's license, passport, or state-issued ID) for record keeping purposes.
2. I understand that I may be asked to pay, in advance for major services such as fillings, extractions, crowns, etc.
3. I understand that payment options available to me are cash or major credit card (Visa, MasterCard, American Express, or Discover).
4. I understand that I will be charged the maximum service charge allowed by law for any returned check, electronic authorization, or any debit sent or provided to Belleair Smiles.
5. I understand that third-party financing is available to me through Care Credit or Lending Club all financing is subject to approval by the lender. A credit check is required.
6. I understand that is not a preferred provider with any insurance company.
7. I understand that insurance claims will only be filed if I provide all information related to my dental insurance, including my social security number to Belleair Smiles. If I choose not to provide Belleair Smiles with my social security number, I understand that I must pay in full for all services rendered.
8. In the event that Belleair Smiles is unable to verify my insurance benefits, payment in full will be required and documentation will be provided to me that would allow me to file a claim for reimbursement.
9. I understand that Belleair Smiles will file my dental insurance claim as a courtesy and accept assignment of benefits from my insurance company as partial payment for services rendered. I understand that benefits may be reduced based on limitations of my insurance carrier.
10. I understand that benefits quoted are only and ESTIMATE and not a guarantee of payment. Benefits quoted are based on information provided by my insurance company.
11. I understand that Belleair Smiles will file my claim(s) a maximum of two (2) times per appointment and that any further insurance appeal is solely my responsibility.
12. I understand that I will be responsible for any fees not paid by my insurance company within sixty (60) days. Reasons for non-payment include, but are not limited to procedure denial, policy deductibles, maximum allowable annual benefits, frequency limitations, usual and customary (UCR) benefits, procedural limitations, or lifetime benefit limitations.
13. I understand that if I opt to discontinue treatment for a procedure after treatment has started, I will be responsible for paying for the doctor's time, materials used, and associated lab fees. These fees will be deducted from any refund that I may be entitled to as a result of prepayment for the requested services.
14. I understand that all account balances over 30 days old will incur a monthly interest rate charged at the maximum legal rate allowed.
15. I understand that I must inform Belleair Smiles, in writing, of any questions or disputes regarding my treatment or charges in a timely manner but not more than 30 days from either the completion of treatment or receipt of the statement of charges. I agree to work with Belleair Smiles to resolve such matters through an informal mediation process rather than through civil litigation.
16. I understand that Belleair Smiles may report delinquent payments to a credit rating bureau, refer my account to a collection agency, and/or take legal action against me for payment in full plus monthly interest, applicable legal fees, attorney's fees, and court costs.
17. I understand that unless patient records are sent directly to another provider, the charge for copies of x-rays is $25; there is a separate $25 fee for copies of treatment records.
18. I understand that Belleair Smiles can charge a fee for appointments that I change with less than 48-hour notice which includes appointments that I do not keep. After two broken appointments, the dentist retains the right to discontinue elective treatment and to dismiss me from the practice.

Print Name_____ Date _____

Signature of Patient or Guardian_____