smilebuilderz
family dentistry & urgent dental care

Personal Information

First Name:_____ Last Name:_____ Date of Birth: _____

Complete Address: _____

Telephone: (Primary):_____ (Secondary):_____ (Work):_____

Personal Email: _____

Physician Name:_____ Office Phone Number: _____

Emergency Contact

Primary Full Name: _____ Telephone:_____

Secondary Full Name: _____ Telephone: _____

Medical Information

Although dental personnel primarily treat 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 interrelationship with the dentistry you will receive.
Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No
Acid Reflux			Eating Disorder			Liver Disease		
AIDS/HIV Positive			Emphysema			Low Blood Pressure		
Addiction			Epilepsy or Seizures			Lung Disease		
Alzheimer's Disease			Fainting Spells/Dizziness			Lymphedema		
Anemia			Glaucoma			Mitral Valve Prolapse		
Angina			Gout			Osteoporosis		
Anxiety			Hay Fever			Parathyroid Disease		
Arthritis			Heart Attack/Failure			Psychiatric Care		
Artificial Joint			Heart Disease			Radiation Treatment		
Asthma			Heart Murmur			Rheumatic Fever		
Autism Spectrum			Heart Pacemaker			Scarlet Fever		
Blood Disease/Disorder			Heart Valve Replacement			Shingles		
Cancer			Hepatitis A, B, or C			Sinus Problems		
Chemotherapy			High Blood Pressure			Stroke		
Cold Sores/Fever Blisters			High Cholesterol			Thyroid Disease		
Congenital Heart Defect			HPV			Tonsillitis		
Depression			Hypoglycemia			Tuberculosis		
Diabetes			Kidney Problems			Tumors		

Do you have or have you had any serious illness not listed above? **Yes** **No**

_____

_____

Women: Are you	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Pregnant?			Taking Oral Contraceptives?			Nursing?		

*If you use oral contraceptives, it is important to note that antibiotics may interfere with the effectiveness of the contraceptive.

	Yes	No	
Are you under a physician's care?			If yes, please explain:
Hospitalized/had an operation (last 5 years)?			If yes, please explain:
Have you had a serious head or neck injury?			If yes, please explain:
Have you ever taken bisphosphonates (Fosamax, Boniva, Actonel, etc.)?			If yes, for how long?
Do you use tobacco of any kind or vape?			How much?

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Medication List (RX, OTC, Herbal)

Name of Medication	Reason for Taking	Dosage	Frequency

Allergies

Are you allergic to any of the following:											
	Yes	**No**		**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Penicillin			Aspirin			Latex			Metal		
Codeine			Sulfa Drugs			Anesthetic			Acrylic		
Milk Protein			Nut			Clove			Seasonal		
Other			If other, please explain:								

Dental Information

Please list any dental concerns you would like to review with your provider. Some examples are tooth pain, jaw pain, sensitivity, tooth fracture, frequent ulcers, dry mouth, or frequent gum bleeding. **Please Print.**

Concerns: _____

_____

_____

_____

_____

_____

_____

_____

The questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Parent/Legal Guardian:_____ Date: _____

SMILEBUILDERZ APPOINTMENT POLICY

Welcome to the Smilebuilderz dental family! As a member of our family, we are committed to providing you with the very best oral health care in addition to exceptional customer service. Missed appointments compromise our ability to provide you the quality of care and service we are committed to. An exclusive time is reserved specifically for you to meet with our provider for your appointment.

- A **missed** appointment is when *you do not attend* a scheduled confirmed appointment.
- A **rescheduled** appointment is when you *change* a scheduled appointment without giving 24 hours' notice.
- If an appointment is **rescheduled** with **less than 2 hours** notice, it will be considered as a missed appointment.
- An **unconfirmed** appointment is when *we have not heard* as to whether you will be attending your reserved appointment time.

We will allow no more than ***two*** rescheduled appointments with less than 24 hours' notice. We will allow no more than ***one*** missed appointment in any twelve-month period to maintain the privilege of scheduling your appointments. After the first missed appointment a letter will be sent reminding you of our Appointment Policy, and notifying you that one more missed appointment may result in your dismissal of our practice, We will help remind you of your appointments through text message, email, and courtesy phone call. If your appointment remains unconfirmed by 9:00 am 2 days prior to your scheduled time, the appointment will be canceled.

Help us keep our commitment to you by making your scheduled appointments a priority.

By signing below, I acknowledge my responsibility in maintaining the privilege of scheduling. I understand the impact of missing or rescheduling my dental appointments on Smilebuilderz to maintain their commitment to my oral health.

Signature of Patient or Responsible Party Date

SMILEBUILDERZ COMMITMENT

We are an elite team of professionals who set the standard for providing quality oral healthcare solutions. We are committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimum oral health.

Our Smilebuilderz family is committed to:

- Delivering the **highest quality of care.**
- Providing specialties in Endodontics, Orthodontics, Periodontics, Pediatric Dentistry and Oral Surgery allows us to deliver exceptional comprehensive care.
- Being **accountable** to you for each and every procedure.
- Offering you **convenient** evening and weekend appointments and emergency walk-in care six days a week.
- Providing affordable dentistry
- Utilizing the most **up-to-date technology** and materials available.

Our goal is to be *your partner in health for a lifetime.* We take our responsibility and commitments to you very seriously. We ask that you strive for the following:

- To be committed to the appointment time you have reserved.
- To be aware that any patient under 18 years of age will need to be accompanied by a legal guardian at all appointments.
- To be prepared with the appropriate estimated patient expense at your appointment.
    - Any estimated expense of $500.00 or greater requires half down to be scheduled and the remaining balance will be due at the time of the appointment.
    - Half of the estimated patient portion is due at time of scheduling for specialty services.
- Notify us as soon as possible if you will be delayed by 5 minutes or more for any appointment.
- Understand that all charges incurred on your account are your responsibility regardless of insurance coverage. Unpaid Insurance balances older than 60 days will become your responsibility. All fees quoted are estimates only and are based upon available benefits, current eligibility and are not a guarantee of payment from your insurance provider.

I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO SMILEBUILDERZ.

_____

Printed Name of Patient

_____

Signature of Patient or Responsible Party Date

SMILEBUILDERZ FINANCIAL POLICY

Thank you for choosing Smilebuilderz as your dental health care provider. We are committed to the success of your treatment. Part of the commitment is your understanding and responsibility for the payment of your account balance.

Our basic financial policy is the following:

FULL PAYMENT OF ESTIMATED RESPONSIBILITY IS DUE AT THE TIME OF SERVICE.
Smilebuilderz accepts cash, check, Visa/MasterCard, Discover, American Express and special financing through Care Credit and Wells Fargo.

ADULT AND MINOR PATIENTS:

Adult patients are responsible for full payment of estimated responsibility at the time of service unless specific arrangements are made prior to the start of treatment. The parent accompanying a minor and the parents/guardians are responsible for full payment of estimated responsibility at time of service.

REGARDING INSURANCE:

We will accept assignment of participating insurance plans and will submit dental claims on our patient's behalf. Your insurance policy is a contract between you and your insurance company. Smilebuilderz is not a party to that contract. Any insurance bill not settled within 60 days will be due in full. You agree to pay our practice all amounts billed regardless of the amount covered by your insurance.

Please be aware that some and perhaps all of the services provided may be non-covered services. You are responsible for the entire balance no matter what the outcome is with your insurance provider. Our estimate of expected coverage does not constitute a representation or guarantee that your benefit provider will pay the amount estimated.

USUAL AND CUSTOMARY RATES

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will take reasonable and proper steps to help you receive the maximum insurance benefits allowed by your insurance plan.

PATIENT RESPONSIBILITY AND ADDITIONAL TERMS

Inability to comply with your payment agreement may lead to dismissal from the practice after three consecutive missed payments. If you or anyone in your family are in orthodontic treatment after three payments have been missed, the only treatment you or your family member will only be eligible for will be de-banding with no retainer.

Should you fail to comply with the terms of this financial policy and Smilebuilderz pursues collection of your unpaid balance, you agree to pay a 25% upcharge to defray the collection costs incurred by the practice, in addition to any balance due. This includes but is not limited to, collection fees, court costs, and reasonable attorney's fees.

The listed items are custom-made for you by our laboratories and cannot be refunded in full if you decide to discontinue treatment. You agree to be assessed the accompanying fees in lieu of your full treatment price for the following procedures if not completed within six calendar months.

Partials/Dentures (per arch) $400
Implant Crowns and Custom Abutments (per item) $900
All other undelivered services (per item).....$200

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to the terms of the Financial Policy of the office of Smilebuilderz, LLC.

Signature of Patient or Responsible Party **Date**

Signature of Co-Responsible Party **Date**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

_____ _____

Printed Name of Patient **DOB**

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the HIPAA Privacy Officer. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of myprotected health information to carryout treatment, payment activities and health care operations.

_____

Signature of Patient or Responsible Party Date

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

RELEASE OF INFORMATION

I,_____, authorize Smilebuilderz to release my information to the following:

Name	Relationship	Date	Initials
Name	Relationship	Date	Initials
Name	Relationship	Date	Initials
Name	Relationship	Date	Initials