REGISTRATION & TREATMENT

PATIENT INFORMATION

Date _____

Name _____ SS#/ID# _____
Last First Middle

Address _____ Birth date _____/_____/_____ Age _____

City _____ State _____ Zip _____ Sex □ Male □ Female

Home Phone (_____) _____ Cell Phone (_____) _____ Business Phone (_____) _____

E-Mail Address _____

Whom may we thank for referring you? _____

In case of an emergency who should we notify? _____ Phone (_____) _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last First Middle

Relationship to Patient _____ Birth date _____/_____/_____ SS#/ID# _____

Phone (_____) _____

Subscriber employed by _____ Phone (_____) _____

Insurance Company _____Group # _____ Subscriber # _____

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? □ Y □ N SS#/ID#_____

Subscriber Name Relationship to Patient_____ Birth date ____/____/_____

Subscriber employed by_____ Phone (_____) _____

Insurance Company _____Group # _____ Subscriber # _____

MEDICAL HISTORY & INFORMATION

Reason for Today's Visit _____ **Date of last dental care** _____

Former Dentist _____ **Date of last dental X-Ray** _____

Please check if you have problems with the following:

□ Bad breath □ Grinding teeth □ Sensitivity to hot or cold □ Bleeding Gums □ Sensitivity to sweets □ Loose teeth / broken fillings

□ Clicking / popping jaw □ Sensitivity when biting □ Food collection b/w teeth □ Sores or growths in your mouth

CONDITIONS

□ Abnormal Bleeding
□ Alcohol Abuse
□ Allergies (environmental)
□ Anemia
□ Angina Pectoris
□ Arthritis
□ Artificial Heart Valve
□ Asthma
□ Blood Transfusion
□ Cancer
□ Chemotherapy
□ Colitis
□ Congenital Heart Defect
□ Depression
□ Diabetes
□ Difficulty Breathing
□ Drug Abuse
□ Emphysema
□ Epilepsy
□ Facial Surgery
□ Fainting Spells
□ Fever Blisters
□ Frequent Headaches
□ 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
□ Pacemaker
□ Psychiatric Problems
□ Radiation Therapy
□ Rheumatic Fever
□ Seizures
□ Sexually Transmitted Disease
□ Shingles
□ Sickle Cell Disease
□ Sinus Problems
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Ulcers
□ Other Conditions (list);
_____
_____
_____

ALLERGIES

□ Aspirin
□ Codeine
□ Dental Anesthetics
□ Erythromycin
□ Latex
□ Metals
□ Penicillin
□ Sulfa
□ Tetracycline
□ Other: _____

Y N

□ □ Do you use tobacco?

Y N IF FEMALE

□ □ Are you taking Birth Control Pills?
□ □ Are you pregnant?
If yes, # of weeks_____
□ □ Are you nursing?

Y N

□ □ Do you snore?
□ □ Do you have sleep apnea?
□ □ Do you have a C-PAP?

SMILE ANALYSIS

□ □ Are you interested in Invisalign (invisible braces)?

□ □ Are you interested in teeth whitening?

□ □ Are you interested in a cosmetic consultation?

□ □ Are you interested in dental implants?

Name of General Physician: _____

Please list any medications you are currently taking: _____

_____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. Payment for all treatment and services rendered are my responsibility.

_____ _____
PATIENTS SIGNATURE **DATE**

If patient is under 18 years old or requires a guardian:

_____ _____
PARENT/ GUARDIAN SIGNATURE **DATE**

_____
Print Patient Name I Guardian Name

FINANCIAL POLICY

Payment is expected at the time of service. For your convenience we offer several payment options including cash, check, debit card (w/ Visa or Master Card logo), credit card and CareCredit.

If you are using Dental Insurance to help with payment, your co-pay will be due at the time of service. We will be happy to file your claim for you; however, your bill is ultimately your responsibility should insurance not cover the expected amount due.

For alternative payment arrangements we require that a valid credit card be held on file. Should you fail to meet your obligation, we may process your credit card for any outstanding balances. We will never use your card without first calling to notify you of the outstanding balance.

This is necessary for us to maintain the level of services and care that all of our patients expect of us. If you have any questions about our financial policy, please feel free to contact our Financial Administrator at your convenience.

Credit Card Type (circle one): Visa Master Card American Express Discover CareCredit

Card Number: _____

Expiration Date: _____/_____

CVV code: _____

Card Holder's Name: _____

I authorize Open Smiles Dental, LLC and Associate to process any outstanding balances on my account to the credit card listed above.

_____ _____
Signature Date

_____ _____
Print Name Date

BROKEN APPOINTMENT POLICY

Open Smiles Dental, LLC knows your time is valuable, and we respect that! In fact, we make it a point to schedule all of our patients with this in mind. Our daily goal is to seat all of our patients on time. In an effort to provide timely service to our patients we never over-book our schedule like so many other healthcare facilities. This makes our time very valuable to us as well. Therefore, to avoid broken appointments and late patient arrivals, the following policy has been adopted:

1. All cancellations or rescheduled appointments must be arranged two business days prior to appointment date.
2. Patients arriving more than ten minutes late may be rescheduled at Open Smiles Dental, LLC's discretion.
3. Patients who...
   - don't show up for their appointment, or
   - reschedule without two business days' notice

   ...will be required to supply us with a valid credit card to secure their rescheduled appointment. No charges shall be placed on the credit card so long as the next appointment is met or rearranged two or more business days prior to the new appointment date. Should the next appointment be broken without following the above guidelines, a **$75.00** missed appointment fee will be charged to the patient's credit card.

To avoid raising our dental fees and allow for all our patients to reserve appointment times when desired, we find it necessary to implement this policy.

Thank you for understanding and respecting our time and policy. If you have any questions regarding this matter, please contact us at 301-843-0225.

_____ _____
Signature Date

_____ _____
Print Name Date