PATIENT INFORMATION

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Cell phone _____ Home phone _____

Mailing address _____ City _____State _____ Zip _____

INSURANCE INFORMATION Not covered by dental insurance

Primary Policy Holder : Self Spouse Spouse's name _____

Primary's Employer _____ Occupation_____

Primary's Social number: _____ Dental Insurance Co._____ Group number_____

As a courtesy to our patients, we will submit insurance claims on your behalf. Please understand that all fees are estimated based on information provided by the insurance, and is not a guarantee of payment by them. In the event that the insurance company does not pay their estimated portion, the patient will be responsible for that amount.

I authorize dental insurance payments (assignment of benefits) to the offices of Friendly Smiles Family Dentistry. _____(initials)

MEDICAL HEALTH HISTORY

Check if you've ever been diagnosed with the following:

- ❑ Cancer: Type/year/status: _____.
- ❑ Heart attack (year _____) or Angina (chest pain)
- ❑ Heart Valve Replacement (year _____)
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Congestive Heart Failure (CHF)
- ❑ Pacemaker
- ❑ High blood pressure Low blood pressure
- ❑ Total Joint Replacement (Knees, Hips, or Other)
- ❑ Bleeding (clotting) Disorder
- ❑ COPD (Bronchitis/Emphysema)
- ❑ Tuberculosis (even if inactive)
- ❑ Kidney/Renal Disease Dialysis
- ❑ Hepatitis (Type:) Other liver disease
- ❑ Diabetes (Type:)
- ❑ Neuroloic/Nerve Condition
- ❑ Seizures (Type:)
- ❑ Depression or Mood Disorder (Type:)
- ❑ Arthritis (Rheumatoid or Osteoarthritis)
- ❑ Herpes/Cold Sores
- ❑ AIDS or HIV positive
- ❑ Headache disorders
- ❑ Anemia
- ❑ Sinusitis
- ❑ Thyroid (Hyper or Hypo)
- ❑ Asthma
- ❑ Alcoholism Drug addiction (Type:)
- ❑ Smoking or chewing tobacco
  - ❑ Current usage: Packs per day _____.
  - ❑ Previous usage: # of Years usage before quitting:___.
    Avg packs per day before quitting _____.

Women:

- ❑ Pregnant: Expected delivery date: _____
- ❑ Possibly pregnant
- ❑ Taking hormones or contraceptives

Please list any other medical conditions you may have:

_____.

_____.

Physician Name & Phone: _____.

_____.

Do you have a TRUE **ALLERGY** to any of the following?
(TRUE - difficulty breathing, swelling, severe rash/itching)

- ❑ Latex
- ❑ Penicillin Other antibiotics
- ❑ Local Anesthesia (Lidocaine)
- ❑ Codeine Hydrocodone
- ❑ Sulfa drugs
- ❑ Aspirin
- ❑ Other: _____

Please list **MEDICATIONS** you are taking:

_____.

_____.

_____.

_____.

_____.

_____.

I did not list all medications_____

Have you ever had Bisphosphonate Drug Therapy ?
(medicine for osteoporosis or bone cancer) Yes No

Please Tell us about your **DENTAL CONCERNS**:

_____.

_____.

_____.

_____.

Appointment Cancellation Policy

Due to the high cost of healthcare, Our office requires a minimum of 24-48 hour notice for appointment cancellation or rescheduling. A $50 fee may be charged for non compliance.

Patient (or Parent) Signature:

_____.

Date: _____.

Friendly Smiles
Family Dentistry

Privacy Policy and Patient Consent for Use and Disclosure of Patient Protected Health Information

This documents describes Friendly Smiles Family Dentistry's use and discloser of your
(PHI) Protected health information, to carry out
(TPO) Treatment, Payment and Healthcare Operations

You have the right to view our Notice of Privacy Practices prior to signing this consent. Friendly Smiles Family Dentistry reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Friendly Smiles Family Dentistry, 7510 W. Aspera Blvd. #105, Glendale AZ 85308.

I have the right to request that Friendly Smiles Family Dentistry restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

ONLY INITIAL where you will allow us to communicate with you regarding your protected health information and Treatment Payment and Healthcare Operations:

_____I will only allow communication of my information in person within the dental office.

_____Voice Mail
With this consent, Friendly Smiles Family Dentistry may call me and/or leave a message on voice mail discussing PHI and TPO.

_____Mail
With this consent, Friendly Smiles Family Dentistry may mail to my home or other alternative location any items that assist the practice in carrying out TPO

_____E-mail: _____@_____
With this consent, Friendly Smiles Family Dentistry may e-mail items that assist the practice in carrying out TPO. Please note email is a NONSECURE form of data transmission. Patients will be required to answer a security question such as "What is your date of birth?", before any information will be sent via email.

_____Family or Friend
With this consent, Friendly Smiles Family Dentistry may speak to _____ regarding my PHI and TPO

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Friendly Smiles
Family Dentistry

CONSENT

The undersigned hereby authorizes the Doctor to take X-Rays, study models, photography or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medications and therapy that may be indicated. I also understand the use of anesthetic agent embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtaiined.

Patient Name:_____-

Patient Signature:_____

(Parent of Child)

Date:_____

Dentist Signature:_____

Friendly Smiles
Family Dentistry

If we received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the entire estimated amount insurance is not expected to pay on the day of service. By law, your insurance company is required to pay each claim within 30 days of receipt. We file all insurance claims on the day of service, so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 30 days, where insurance has paid or not. If you have not paid your balance within 60 days a re-billing fee of 1.5% will be added to your account each month until paid. We will be glad to send a refund to you if your insurance pays us.
PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of the treatment. We at no time guarantee what your insurance will or will not do with each claim. We also cannot be responsible for any errors in filing your insurance. Once again, we file claims as a courtesy to you.

Dental Insurance FAQs:

SHOULD INSURANCE PAY 100% OF ALL PRQCEDURES?
No, dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. Most plans only pay between 50-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage, or the type of contract your employment has set up with the insurance company.

WHO DETERMINES WHAT MY BENEFITS ARE?
Your benefits are NOT DETERMINED by our office. You may have noticed that sometimes your dental insurance reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable, or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate. Insurance companies set their own schedules, and each company uses different set of fees they consider allowable. These allowable fees may vary widely, because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR fee. Frequently, this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit.
Unfortunately, some insurance companies imply that your dentist is "overcharging", rather than say that they are "underpaying", or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

EXPLAIN HOW DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED
When estimating dental benefits, deductibles and percentages must be considered. To illustrate, assume the fee for service is $150.00. Assuming that the insurance company allows $150.00 as its usual and customary (UCR) fee, we can figure out what benefits will be paid. First a deductible (paid by you), on average $50, is subtracted, leaving $100.00. The plan then pays 80% for this particular procedure. The insurance company will the pay 80% of $100.00, or $80.00. Out of $150.00 fee they will pay an estimated $80.00 leaving a remaining portion of $70.00 (to be paid by the patient). Of course, if the UCR is less than $150.00 or your plan pays only at 50% then the insurance benefits will also be significantly less.

I _____, have read and understand that the fees presented to me today are only an estimate of what my responsibility will be for the treatment rendered to me today. I agree to pay for my responsibility of the charges on the day that the treatment is rendered, and any fees that are underpaid or denied by my insurance company. I understand that my insurance is billed as a courtesy and that if payment from my insurance has not been received within 30 days, I will become responsible for the remaining balance.

_____ _____ _____
Print name Signature Date

Friendly Smiles
Family Dentistry

OUR FINANCIAL POLICY:

Payment in full is due when services are rendered unless other arrangements have been made. We offer several options of payment for the services we provide: Cash, Check, Visa, Mastercard. Since we believe that your health should not be compromised because of a lack of immediately available funds or insurance benefits, we also provide payment plans through Care Credit and Springstone Financial. These two companies allow our patients, who qualify, the opportunity to spread out the cost of treatment into small monthly payments. Any patients who would like to take advantage of this convenitent option for payment needs simply to fill out an application. Please note that there is a 5% application processing fee we charge for this service.

USUAL & CUSTOMARY FEES:

We are commited to providing excellent dental treatment to all of our patients. Our fees and services reflects our commitment to the quality our patients deserve and expect when visiting a dental practice and are not guided by arbitrsry demterminations by the insurance companies.

INSURANCE:

As a courtesy to our patients, we will bill your insurance company as our office is committed to helping you maximize your benefits. HOWEVER, YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOUR INSURANCE COMPANY AND YOURSELF. As a health care provider, we are not party to your agreement with your insurance. INSURANCE POLICIES VARY AND SERVICES PROVIDED MAY NOT BE COVERED. THE BALANCE IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE PAYS OR NOT.

MISSED APPOINTMENT:

One of the ways we keep our fees more affordable is by avoiding missed appointments. Although we understand that occasionally our patients will need to reschedule their appointments, please notify us 48 hours prior to your appointment to avoid a fee of $50 for every half hour scheduled. It is our office policy that we will not offer you another appointment after three missed appointments.

RETURNED CHECKS:

We will charge $50.00 for all returned checks. All fees incurred to collect payments will be payable by the patient.

CHILDREN UNDER 18:

We require all children under the age of 18 to be accompanied by a parent or legal guardian. During the time the patient is in the office, we request the parents/guardian stay in the office as treatment may change or questions may arise that only the parents/guardian can answer. The patient registration form must be signed by the parent or legal guardian accompanying the minor at the first appointment. That guarantor ultimately bears the legal resonsibility for payment. We are unable to know the financial responsibilties of divorced parents. We will look to the adult accompanying the minor for payment.

I understand and agree that I am personally responsible for all fees, regardless of insurance coverage. I agree to pay any attorney fees, collection fees, or any cost that may occur to satisfy my financial obligation for the dental treatment provided to me and my family by Friendly Smiles Family Dentistry. I heareby authorize any of the doctors to proceed with and perform the dental treatments as explained to me. I understand that dentistry is not an exact science; therefore, reputable practitioners cannot guarantee results. I understand and agree to the financial office policy above.

X_____ _____

Signature of Patient or Responsible Party *Date*