SMITH AND SMITH DENTAL ASSOCIATES

FINANCIAL POLICY

Full Payment is due at the time of service
We accept Cash, Check, Visa/Master Card, American Express, and Discover

Traditional Indemnity Insurance/PPO Insurance The entire fee charged for services rendered is *YOUR OBLIGATION*. Smith and Smith Dental Associates have agreed to bill these insurance carriers for all services rendered. However, authorization from your insurance company does not always guarantee payment. The percentage that your insurance company has not contracted to pay is expected prior to services being rendered. Once your insurance has paid, any balance that remains is due and payable by you. If your insurance carrier has not paid within 90 days following the filing of the claim, the outstanding portion is due and payable by you immediately. ***Managed Care Plans (HMO)*** These plans entitle you to a discount of our fees. Your fee is determined by your insurance company and not by our office. Your insurance company is not billed by our office and does not pay a percentage on services rendered. All co-pays are due prior to treatment. ***Missed Appointments*** Unless cancelled, at least 24 hours in advance, there is a charge of $20. This charge is to be paid prior to receiving any further treatment.

INFORMED CONSENT FOR DENTAL TREATMENT

I understand that by signing this consent I am in no way obligated to any treatment. I authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination- for example root canal therapy following restorative procedures. I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized.

_____ _____

Signature of patient or patient's authorized representative *Date*

INFORMED CONSENT FOR DENTAL SURGERY (EXTRACTIONS)

Alternatives to removal of teeth have been explained to me (root canal therapy and no extractions). I understand that removing teeth does not always remove the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock.

I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed, and permit prescribed diagnostic procedures.

_____ _____

Signature of Patient or Patient's authorized representative *Date*

Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial ____ SEX: M F BIRTHDATE _____ AGE____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name_____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle _____ MARITAL STATUS _____

RESIDENCE Street _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____ (LAST / FIRST / MIDDLE)

EMPLOYER _____ NO. YEARS EMPLOYED ____

OCCUPATION _____ SOC. SEC. # _____

WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY, STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain	#	LACK of concern	#
COST of treatment	#	MISSING work time	#

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For What?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	☐	☐
Do you SMOKE?	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	A.I.D.S./A.R.C./HIV Pos.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (Hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Venereal Disease	Alcoholism
Ulcers	(Syphilis, Gonorrhea, etc.)	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances? _____

If yes, please list: _____

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE NO. _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

 RMC DENTAL (303) 751-3321

SMITH AND SMITH AND DENTAL ASSOCIATES
1190 W. EDGEWOOD AVENUE, SUITE B
JACKSONVILLE, FLORIDA 32208

Patient Consent and Rights

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment; Obtaining payment from third party payers (eg. My insurance company)The day to day healthcare operations of your practice. I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. 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.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Patient's name (Print) *Relationship to Patient*

_____ _____

Signature of Patient or Responsible Party, if a minor *Date*

MEDICATION FORM

Primary Care Physician: _____

Physician Phone Number: _____

Name of Medication	Dose (mg)	Direction	Reason for taking