DREAM SMILE DENTAL - REGISTRATION FORM

*INTER OFFICE: ☐WALKIN ☐RETURNING PT ☐APPOINTMENT	CHART #	DATE:

LAST:	FIRST:	MI:	NICKNAME/PREFERRED NAME:

ADDRESS:	CITY	STATE	ZIP CODE

HOME#	WORK#	MOBILE#

☐MALE ☐FEMALE	MARITAL STATUS: ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED	DOB:	AGE:	LANGUAGE:	RACE:

*SOCIAL SECURITY: - -	*DRIVER LICENSE: - -

*EMERGENCY CONTACT NAME:	RELATIONSHIP:	PHONE# ( ) -

PERMISSION TO RECEIVE ELECTRONIC COMMUNICATION: ☐YES ☐NO ☐TEXT ☐EMAIL ☐BOTH

EMAIL: @	MOBILE: ( ) -

EMPLOYER:	☐ FULL TIME ☐PART TIME	STUDENT: WHERE:_____ ☐ FULL TIME ☐PART TIME

EMPLOYER ADDRESS:	CITY/STATE	ZIPCODE

HOW DID YOU HEAR ABOUT OUR OFFICE: (CHECK ONE)
☐FAMILY MEMBER/DS EMPLOYEE ☐SOCIAL MEDIA ☐INSURANCE ☐OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE:	POLICY#	GROUP#

SUBSCRIBER: ☐ SELF ☐ PARENT/GUARDIAN	PARENT/GUARDIAN NAME:	* ☐MEDICAID ☐DMO ☐ PPO

2ND INSURANCE:	POLICY#	GROUP#

SUBSCRIBER: ☐ SELF ☐ PARENT/GUARDIAN	PARENT/GUARDIAN NAME:	* ☐MEDICAID ☐DMO ☐ PPO

I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.

By signing below, I authorized that you may verify and exchange information on me or an additional applicants requiring reports from credit reporting agencies. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I authorize release or any information relating to any dental claim or claims.

I understand that each dentist is individually responsible for dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

SIGNATURE OF PATIENT/GUARDIAN, IF PATIENT IS A MINOR:	DATE: / /

(OFFICE USE ONLY) OFFICE NOTES:

EFFECTIVE: 02/2019

PLEASE COMPLETE ALL AREAS OF FORM

Dream Smile Dental

HIPAA NOTICE OF PRIVACY PRACTICES

A. I, acknowledge that I have received a copy of this office's **NOTICE OF PRIVACY PRACTICES** or that this office's **NOTICE OF PRIVACY PRACTICE** was made available to me receive.

B. I hereby authorize Dream Smile Dental to release dental health information for myself or my family's dental health and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations; This Auth does not expire unless we received a written stop letter.

NOTE: To recipient of information. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the **federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)** or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable **HIPAA** requirements before releasing the requested records. CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request. (Charges may apply for copies of records).

I, consent to the use and disclosure of my personal health information by your office for treatment, billing/ Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

I GIVE PERMISSION TO:

PERSON NAME_____

C. PATIENT CONSENT TO RECEIVE MAIL AND /OR TELEPHONE MESSAGES/ EMAIL/TEXT MSG

I give permission to:

Send a call appointment reminder to your home OR contact you or leave appointment, billing or dental information on your answering machine/ Telephone/ voice mail/ e-mail/text.

I, acknowledge that I read & accept.

A. NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION.
B. HIPAA INFORMATION
C. PATIENT CONSENT TO RECEIVE MAIL AND/ OR TELEPHONE MESSAGE/ EMAIL /TEXT MSG

_____

Signature of patient or Guardian if Minor

Date:_____|_____|_____

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Dream Smile Dental

Consent for Services and Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL Thank you for choosing Dream Smile Dental practice as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor.

FINANCIAL POLICY

Thank you for choosing out practice to serve your dental practice to serve your dental needs. Please take the time to read the following and sign/ date the bottom of this form to accept Financial Policy .Insurance balance are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balance which are not paid within 60 days may be billed to you. Please keep your walk-out statement and follow up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility. Major service may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made. Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment. There will be a fee of $30.00 for any checks returned as Non-Sufficient funds (NSF). Patient balance that go unpaid for 30 days or more may incur one or more of the following charges to subject to state and federal regulation maximum: interest charges of 1.5 % per month OR 18% APR, Collections fees (up to 42% of the full balance), Legal fees for collection services.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All ESTIMATED portions and deductibles are due prior to treatment. In the event YOUR insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

USUAL AND CUSTOMARY RATES Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS Adult patients are responsible for full payment at time of service.

MINOR PATIENTS The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, American Express, Discover, Care Credit, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS

We respectfully ask that you give us a minimum of 48hour notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance over 60 days past due.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

☛ _____

Date: _____ Relationship to Patient: _____ Signature of patient, parent or guardian

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Dream Smile Dental

MEDICAL HISTORY

PATIENT NAME_____ **BIRTH DATE**_____

Although Dream Smile Dental 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. Thank you for answering the following questions.

Have you been to dentist in less than 6 months? ☐Yes ☐No If Yes, please Explain:_____

Do you have current full mouth X-ray copy from Previous Dentist? ☐Yes ☐No Date_____

Are you under a physician's care Now? ☐Yes ☐No If Yes, please Explain:_____

Have you ever been hospitalized or had a major operation? ☐Yes ☐ No If Yes Please Explain:_____

Are you taking any medications, pills or drugs? ☐Yes ☐ No If Yes Please Explain:_____

Are you on special diet? _____

Do you use controlled substances? _____

WOMEN Only
Pregnant/ Trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing Y N

Are you **ALLERGIC** to any of the following?
Aspirin ☐ Penicillin ☐ codeine ☐ Local Anesthetics ☐ Acrylic Metal☐ Latex☐ Sulfa drugs☐

Do you have, or have you had, any of the following:

☐ **Artificial heart Valve**	☐ **Epilepsy**	☐ **Lung Disease**
☐ **AIDS/HIV**	☐ **Fainting**	☐ **Pacemaker**
☐ **Anemia**	☐ **Glaucoma**	☐ **Phem-Fen**
☐ **Angina**	☐ **Epilepsy**	☐ **Psychiatric Care**
☐ **Arthritis**	☐ **Heart Attack**	☐ **Rheumatic Fever**
☐ **Asthma**	☐ **Heart Surgery**	☐ **Sinus Trouble**
☐ **Bleeding Problems**	☐ **Heart Murmur**	☐ **Sleep Apnea**
☐ **Cancer (type)**_____	☐ **Heart Problems**	☐ **Smoking Tobacco**
☐ **Chemo/Rad Therapy**	☐ **Hepatitis**	☐ **Stroke**
☐ **Cosmetic Surgery**	☐ **High Blood Pressure**	☐ **Thyroid Problems**
☐ **Diabetes**	☐ **Jaundice**	☐ **TMD or TMJ**
☐ **Dizzy Spells**	☐ **Joint Replacement**	☐ **Tuberculosis**
☐ **Drug Addiction**	☐ **Kidney disease**	☐ **Venereal Disease**
☐ **Emphysema**	☐ **Liver Problems**	☐ **Other medical conditions (please**
	☐ **Low Blood Pressure**	**list):**_____

To the best of your knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature Of Patient/Parent/Guardian✒_____ **Date**_____

Signature Of Doctor ✒_____ **Date**_____

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Dream Smile Dental

Informed Consent: General Dentistry

All patients complete 1 thru 4 below, and 5 thru 13 as needed.

1. EXAMINATIONS AND X-RAYS
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

2. DRUGS, MEDICATION AND SEDATION
I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am current taking.

3. CHANGES IN TREATMENT PLAN
I understand 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, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)
I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

5. DENTAL PROPHYLAXIS (CLEANING)
I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

6. FILLINGS
I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

7. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all 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, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

8. CROWNS, BRIDGES, VENEERS AND BONDING
a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

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9. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

10. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

11. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

12. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

13. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

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 I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

I read and consent all above.

Signature_____ **Date:**_____

Doctor:_____ **Date:**_____

EFFECTIVE: 02/2019

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