Gilbert Smiles
Family & Cosmetic Dental Care

NEW PATIENT REGISTRATION

Date: _____

First Name | Last Name | Preferred name | MI | Date of Birth | Age

Address | City | St: | Zip | Social

Cell Phone | Work Phone | . | Home Phone

Email: | Employer: | Occupation

Gender- Circle One Female Male **Marital status- Circle One** Married Single Divorced Widowed

Emergency Contact Name: | Relationship: | Cell Phone

If the patient is a minor please name the accompanying Parent/Guardian who is responsible for the patient if different than the emergency contact

First Name: | Last Name: | Relationship | Cell Phone:

Do you have Dental Insurance to bill for your services? If Yes please fill out below if not circle CASH

Primary Insurance Information:	Secondary Insurance Information:
Subscriber Name	Subscriber Name:
Date of Birth:	Date of Birth:
Relationship to Subscriber: Self Spouse Child Other	Relationship to Subscriber: Self Spouse Child Other
Subscriber ID/SS#:	Subscriber ID/SS#:
Employer:	Employer:
Insurance Company:	Insurance Company:

Whom may we thank for referring you to us or how did you hear about us?

MEDICAL AND DENTAL HISTORY INFORMATION

Today's Date: _____

Last Dental Visit:		Reason for today's visit	
How often do you brush your teeth?		How often do you floss?	
Do your gums bleed when you brush?	Yes / No	Do you have problems with bad breath?	Yes / No
Have you ever had an oral cancer screening?	Yes / No	Ever been treated for periodontal disease?	Yes / No
Popping or clicking near ear when you chew?	Yes / No	Prone to frequent headaches?	Yes / No
Ever had complications from an extraction?	Yes / No	Do you snore?	Yes / No
Sores, blisters or swelling on inside of mouth?	Yes / No	Do you clench or grind your teeth?	Yes / No
Any allergic reaction to a crown or metal filling?	Yes / No	Teeth sensitive to hot, cold or pressure?	Yes / No
Do you use an electric toothbrush?	Yes / No	Have you ever had braces/orthodontic care?	Yes / No
On a scale of 1 - 10, 10 being the highest, how important is your dental health to you? 1 2 3 4 5 6 7 8 9 10			
If you could change something about your smile what would it be?			

Health History

Please select any medical conditions or illnesses you are currently listed below check mark the box:

- ☐ Asthma
- ☐ Artificial Valve
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Alzheimer's
- ☐ Convulsions
- ☐ Blood Disease
- ☐ Cold Sores
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Congenital Heart
- ☐ Cancer if yes Type? _____
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Genital Herpes
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Epilepsy/Seizure
- ☐ Jaundice
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Psychiatric Care
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Kidney Disease
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Shingles
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Mitral Valve
- ☐ Drug Addiction
- ☐ AIDS/HIV Positive

Have you had any serious illness not listed above? ☐ Yes ☐ No

If yes, please explain: _____

Please list all medications you are taking: _____

Have you recently been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, please explain: _____

Women Only-Please check any box: ☐ Pregnant- Due date? ☐ Trying to conceive ☐ Nursing ☐ Oral Contraceptives

Do you use tobacco? Circle Yes or No If yes, please circle what kind? Smoke Chew Vape

Do you use controlled substances/recreational drugs? Circle Yes No If yes, what kind?

Are you allergic to any known medications or materials listed below? ☐ Yes ☐ No-Select NKDA If Yes Please circle if you're allergic to any of the following:

Aspirin Penicillin Codeine Sulfa Latex Local Anesthetics Acrylic Metal Bananas Other: _____

Are you currently under the care of a doctor? ☐ Yes ☐ No - Name of Physician: _____ Phone _____

Patient/Parent Guardian Printed Name _____ Patient/Parent Signature to be kept on file _____ Date _____

Gilbert Smiles
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Welcome to Gilbert Smiles! To ensure you have the best experience and care we ask you read the following policies thoroughly and initial after each topic is read as an acknowledgment.

Mission Statement

Our goal is to build a long term relationship between our staff and our patients so that we can provide quality, consumer friendly, dental services the whole family can value and afford in a happy and healthy environment.

Communication

We do our best to provide a top notch communication platform that notifies our patients of upcoming appointments. These automated text and email messages are sent 1-2 hours after you make an appointment and can be added directly into your calendar. As your appointment date nears a confirmation email is sent 6 days prior and a test 4 days prior in which we require a confirmation to let us know you will be here. If you need to change or cancel an upcoming appointment please give us the courtesy and message back to reschedule or cancel.

Scheduled Appointments

Your dental appointment represents a shared responsibility and in order to have quality dental care at affordable costs, these appointments must be kept. We require a MINIMUM OF 24 HOUR NOTICE to cancel or reschedule and we need confirmation for every reserved appointment time. Due to our high appointment demands, failure to confirm your appointment after multiple attempts, may result in our need to cancel your appointment at our discretion. I understand and agree that if proper notice is not given, I will be charged a minimum fee of $75 per hour of missed appointment.

Insurance Agreement

We will file claims on your behalf as a courtesy to you. Please understand that this is a medical facility and Dr. Swain cares about your health. It is Dr. Swain's responsibility to advise you of the status of your dental health and inform you of treatment needed based on your specific needs, NOT based on our insurance coverage.

It is your responsibility to provide us with your correct insurance information, including the insurance company name, address, phone number, group name and number and any other pertinent information, as well as cooperate with your insurance company to provide information to them if requested. I understand this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

If we are unable to bill your insurance or provide you with an estimate if the information we have is not up to date. We do our best to give you the best estimate on what your insurance will pay and what your portion will be for treatment. Payment is due on the day of treatment.

Assignment of Benefits

I hereby authorize my insurance company to pay directly to my dentist, benefits accruing to me under my policy. I hereby authorize Gilbert Smiles staff to make insurance inquiries on my behalf to insure proper handling and payment of all claims.

General Dentistry Informed Consent for Treatment

This informed consent includes but is not limited to: Extraction teeth, Dental implants, Dentures or partial dentures, Local anesthesia and medicines, Restoring teeth with fillings or crowns, bridges, veneers, inlays, or onlays, Root canals. I understand that specific informed consents may be made available for any or all of the above procedures. I understand that dental treatment contains no guarantees, warranty, or assurance of success. All dental procedures have certain risks; including possible side effects from medicines used. The risks include, but are not limited to: allergic reactions, cuts/abrasions, tenderness/bruising and tooth sensitivity.

Financial Policy

We are committed to providing you with the best possible care. In order to achieve this goal we need your assistance and understanding of our payment policy. Payment for treatment is due on our before the day services are performed unless other arrangements have been made and approved in advance. We accept all major credit cards, cash, and Care Credit accounts.

I understand that all dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. After the insurance has paid on your claims we will send you a statement. If after 3 billings cycles we have not received your payment we will run your card on file for the outstanding balance.

If I carry insurance, I understand if any balance becomes delinquent over thirty (30) days, it is agreed that Gilbert Smiles may impose a late payment charge of 3% per month (or maximum allowed by law). I understand and agree to pay any unpaid balance within 90 days.

ANY AMOUNT NOT PAID BY YOUR INSURANCE, REGARDLESS OF THE REASON IS YOUR RESPONSIBILITY.

For your convenience we will scan your preferred credit card (Health Benefits/Personal) into our system and all card information will be encrypted for your protection. By signing below I am authorizing Gilbert Smiles to run the aforementioned payment for my active family members for the balance due.

Signature Date

Agreement to Terms and Conditions

I, the undersigned, agree to all financial policies as listed above.
I understand that all dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services.

By signing below I also acknowledge being provided with a copy of “Dental Insurance Basics” (pages 1-3) that is designed to better explain how my dental insurance works and answer any questions I may have.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE WITH THEIR CONTENT.

A notice/copy of Gilbert Smiles HIPAA Privacy Practices has been made available to me explaining how Gilbert Smiles protects my confidential health information and what my rights are as a patient. I give permission to Gilbert Smiles to contact me in writing, by e-mail or by telephone at home, work, or cellular phone to discuss any matters related to my account, appointments or any other matter relating to my treatment and care.

On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection costs, attorneys fees, and any other costs incurred to enforce collection. A $35 fee will apply for all checks returned for insufficient funds or closed accounts, and may prevent us from accepting checks as a form of payment for your dental treatment in the future.

Printed Patient/Responsible Party Name

Patient/Responsible Party Signature on file Date

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Oral Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both incidence and mortality rate of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors**. Oral cancer risk patient profile is as follows:

Oral cancer risk by patient profile is listed below:

Increased Risk: Patients age 18-39 and sexually active patients (HPV 16/18)

High Risk: Patients age 40 and older; tobacco users younger than age 40

Highest Risk: Patients age 40 and older and lifestyle risk factors (tobacco use); patients with a history of oral cancer

We have incorporated ViziLite Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however this exam may not be covered by your insurance. The fee for this enhanced exam is $65.00.

YES ☐ I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financially responsibility for this enhanced examination.

NO ☐ I decline the ViziLite Plus exam at this time.

Printed name Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgment****

If the patient is under 18 years of age, a parent or legal guardian must sign.

I, _____, have received a copy of this office's Notice of Privacy Practices.
{Please Print Patients Name}

_____
{Signature of Patient or Parent/Legal Guardian}

_____
{Date}

Pre-medication, billing statements and appointment reminders:
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment or provide notice of a billing statement or appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone. I also authorize this office to remind me of this information on any reminders that the office will mail or email to me.

Our office requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members and/or Friends

Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits or financial/billing information, and/or the request results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over insurance benefits, and/or the results of tests and procedure to the family members and/or friends indicated below. This consent form will not allow our office to release any other information about you. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except where we have already made disclosures in reliance on your prior consent. I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits or financial/billing information, and/or the results of tests and procedures.

1. **Individual Name_____ Relation to Patient: _____**
2. **Individual Name_____ Relation to Patient: _____**

_____
{Signature of Patient or Parent/Legal Guardian} (DATE)