SMILES BY DESIGN

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Patient Information

Patient Name: _____ Date: _____
First MI Last Preferred Name

Email: _____ Gender: Male / Female Marital Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Responsible Party Information

☐ ***SAME AS ABOVE*** Name: _____ Relationship To Patient: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell) : _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? _____

Health Information

Date of last dental visit: _____ Reason for this visit _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS / HIV
☐ Allergic Medication / Latex / Food _____
☐ Acne Medication
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Blood Thinner Medication
☐ Cancer
☐ Diabetes - Type 1 or 2
☐ Insulin _____
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Hay Fever
☐ Head Injury
☐ Heart Disease
Heart Attack _____
☐ Heart Murmur
☐ Hepatitis - Type _____
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnant
Due Date _____
☐ Radiation / Chemo
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke _____
☐ Thyroid Low / High
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ I have used Fen-Fen

Premedication Required
Yes / No

☐ Heart _____

☐ Joint _____

☐ Sleep Apnea
CPAP - Yes / No
Snore Appliances - Yes / No
Type: _____

- Are you taking any medications? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician other than regular check-ups? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any serious problems associated with previous dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____

Insurance Information

PRIMARY DENTAL POLICY

Insurance Company Name: _____ Type of Plan - Indemnity / PPO / HMO / Discount Plan / COBRA

Name of Policy Holder : _____
First Last

Policy Holder's Birth Date: _____ SS# / ID#: _____ Group #: _____

Policy Holder's Employer Name: _____ Insurance Phone #: _____

Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECONDARY DENTAL POLICY

Insurance Company Name: _____ Type of Plan - Indemnity / PPO / HMO / Discount Plan / COBRA

Name of Policy Holder : _____
First Last

Policy Holder's Birth Date: _____ SS# / ID#: _____ Group #: _____

Policy Holder's Employer Name: _____ Insurance Phone #: _____

Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

MEDICAL INSURANCE POLICY

Insurance Company Name: _____ Type of Plan - PPO / HMO / Affordable Care Act / Medicare

Name of Policy Holder : _____
First Last

Policy Holder's Birth Date: _____ SS# / ID#: _____ Group #: _____

Policy Holder's Employer Name: _____ Insurance Phone #: _____

Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

CANCELLATION FEE -To avoid a cancellation fee, our office requires a 24 hour notification to postpone, reschedule or cancel a scheduled dental appointment. Any failed appointments will be charged a cancellation fee based on the appointment time scheduled. Any messages left on our answering machine will have a date/time stamp per message.

PATIENT PRIVACY-Due to patient privacy and safety, only the patient is allowed to be in the operatory.

INSURANCE & ADDRESS CHANGES-Please notify the office if your insurance policy has changed or terminated prior to your appointment.

NEW PATIENTS-New patients scheduling for their first appointment will typically have an exam, x-rays and a cleaning. We do not provide a treatment plan for the first visit. As the patient or parent of a minor patient, please make financial arrangements prior to your appointment if necessary. Otherwise, we will proceed with the scheduled appointment.

CONSENTS & PAYMENT-As a condition of your treatment by Smiles By Design, financial arrangements and treatment consents must be made prior to receiving any dental treatment.

FINANCE CHARGE/RETURN CHECK FEE-A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. Returned bank checks will be charged $35 per transaction.

As a courtesy to our patients who carry dental insurance, Smiles by Design will file and submit all insurance claims on your behalf. You are responsible to pay your estimated portion at the time of service. Estimated insurance benefits are subject to actual payment by your insurance carrier. Ultimately, you will be responsible for any remaining balances.

I understand that the estimated fees listed for my dental treatment can only be extended for a period of 90 days and insurance rates can change at any time without notice.

In consideration for the professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Dr. McElroy & employees to call my home, work, cell and/or email to discuss matters related to this form and/or other dental treatment.

I acknowledge that upon my request, I may receive a copy of the Dental Materials Fact Sheet (adopted by the Dental Board of California, dated October, 2001).
I acknowledge that, upon my request, I can be furnished with a copy of this office's Notice of Privacy Practices.

I have read the above conditions for my dental treatment and consent of services and agree to the Smiles By Design office policies. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, insurance and contact information, I will immediately inform Dr. McElroy and/or the Smiles By Design dental office.

_____ Date: _____
Signature of patient or parent / guardian

_____ Date: _____
Signature of treating dentist