Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (cell): _____ email _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact and phone # _____ c
+/

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

# Insurance Information

## Primary Person Insurance is under

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insured's Social Security # _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Insurance Co Phone number _____

## Secondary insurance

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

## Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Internet ☐ Insurance Co ☐ Driving By ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

**Consent for Services**

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.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care.

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

_____ Date: _____ Relationship to Patient: _____

*PATIENT NAME:*_____ *DATE OF BIRTH:*_____

***MEDICAL HISTORY:*** *CHECK ONLY THAT APPLY*

| | | | | | |
|---|---|---|---|---|---|
| *Anemia* | | *Dry Mouth* | | *Fainting or Dizziness* | |
| *Angina/Chest Pain* | | *Asthma* | | *Cortisone Medicine* | |
| *Artificial Heart Valve* | | *X-Rays Treatment(Radiation)* | | *Genital Herpes* | |
| *Autoimmune Disorder* | | *Sinus Problems* | | *Pain in Jaw Joints* | |
| *Blood Disease* | | *Hives or Rash* | | *Stroke* | |
| *Breathing Problems* | | *Renal Dialysis* | | *Convulsions* | |
| *Bruise Easily* | | *Excessive Thirst* | | *Epilepsy or Seizure* | |
| *Congenital Heart Disorder* | | *Bloody Sputum* | | *Artificial Joint* | |
| *Excessive Bleeding* | | *Hypoglycemia* | | *Glaucoma* | |
| *Heart Murmur* | | *Hay Fever* | | *Rheumatism* | |
| *Heart Pace Maker* | | *Chemotherapy* | | *Drug Addiction/Alcoholism* | |
| *Heart Surgery* | | *Stomach/Intestinal Disease* | | *Cold Sores* | |
| *Heart Trouble/Disease* | | *Frequent Cough* | | *Arthritis/Gout* | |
| *Hemophilia(Bleeding Problems)* | | *Hepatitis A(Infectious)* | | *Dental Anxiety* | |
| *High Blood Pressure* | | *Ulcers* | | *Thyroid Disease* | |
| *Leukemia* | | *Hepatitis B or C* | | *Psychiatric Care* | |
| *Low Blood Pressure* | | *AIDS* | | *Herpes* | |
| *Lung Disease* | | *HIV Positive* | | *Need Premedication* | |
| *Mitral Valve Disorder* | | *Emphysema* | | *Dementia / Alzheimer's* | |
| *Recent Blood Transfusion* | | *Kidney Problems* | | *Alzheimer's Disease* | |
| *Rheumatic Fever* | | *Cancer* | | *Tumors or Growths* | |
| *Scarlet Fever* | | *Tuberculosis* | | | |
| *Sickle Cell Disease* | | *Liver Disease* | | | |
| *Swelling of Limbs* | | *Yellow Jaundice* | | *Other* | |
| *Unexplained Fever* | | *Diabetes* | | | |

- *Are you allergic to anything? ____Aspirin_____Penicillin ____Codeine _____Acrylic _____Latex Other*_____
- *Do you have a specific problem?* _____
- *Do you like your smile?*_____
- *Are you aware of clenching and/or grinding your teeth? _____No _____Yes ***Do you wear a night/bite guard? _____No ____Yes*
- *Acid Reflux? _____No _____Yes*

- *Are you pregnant? __No __Yes ** Do your gums bleed ____No _____Yes*
- *Do you smoke or use tobacco ____No ____Yes ** Do you Vape ____No _____Yes*
- *Have you had any major surgeries? _____No ____Yes ** Are you under a physician's care _____No _____Yes*
- *Are you on any blood thinners ____No _____Yes **Last dental visit?*_____
- *Any other serious illness? __No __Yes, please specify*_____
- *Have you been diagnosed with Sleep Apnea?* _____*Do you snore?*_____ *****CPAP Machine ?*_____

*LIST OF MEDICATIONS:*_____

********To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail. ********

*X*_____ *Date:*_____ *Reviewed by:*_____
*Patient Signature (Parent or Guardian)*

*Date*_____ *Changes*_____ *Initials*_____ *BP*_____ *Reviewed by*_____

*Emergency Contact/ Relationship* _____ *Phone Number:* _____

# the smile

## APPOINTMENTS & FINANCIAL INFORMATION

Patient's Name: _____ Date Of Birth: _____

*~APPOINTMENTS~*

We understand that a missed appointment can happen, but we greatly appreciate consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment. This allows us the opportunity to offer that appointment to another patient who needs to see the doctor. If multiple occasions arise that you fail to give at least a 24-hour notice of cancellation, there will be a fee billed to your account.

*~FINANCIAL~*

Payment (or *Estimated* payment) is due at the time services are rendered, unless other arrangements have been made with our financial coordinator. If you need to make payment arrangements, please speak with out financial coordinator before treatment is rendered.

*~INSURANCE~*

Dental Insurance is a contract between you and your insurance carrier, not between the insurance carrier and this office. Insurance companies can take up to 90 days for claims to be paid. It is the responsibility of the patient/guardian to be aware of their plan limitations and waiting periods.

We assume no responsibility for what your insurance carrier will or will not pay. Please understand that there are many different benefit packages offered by numerous insurance companies and we cannot possibly know the details of each one. We will provide you with an *ESTIMATED* co- payment amount at the time services are rendered, however any remaining balance after your insurance company has paid, will be the responsibility of the patient/guardian.

All 'estimated payments' will be due at the time of service. For your convenience, we accept: Visa, Mastercard and Discover, in addition to cash, personal check and Care Credit.

Our office is committed to providing the best treatment for you, regardless of insurance coverage. Our treatment and fees remain the same whether a patient has insurance or not and we want to be flexible in these changing times and will do our best to make this work for everyone.

☐ I have read and agree with the policies stated above for The Smile PS

Patient/Guardian Signature: _____ Today's Date: _____

~FOR OFFICE USE ONLY~

We attempted to obtain written acknowledgment but could not be obtained because:

- ☐ Individual refused to sign
- ☐ Other – Please specify below
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

_____

_____

# the smile

## APPOINTMENTS & FINANCIAL INFORMATION

Patient's Name: _____ Date Of Birth: _____

*~APPOINTMENTS~*

We understand that a missed appointment can happen, but we greatly appreciate consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment. This allows us the opportunity to offer that appointment to another patient who needs to see the doctor. If multiple occasions arise that you fail to give at least a 24-hour notice of cancellation, there will be a fee billed to your account.

*~FINANCIAL~*

Payment (or *Estimated* payment) is due at the time services are rendered, unless other arrangements have been made with our financial coordinator. If you need to make payment arrangements, please speak with out financial coordinator before treatment is rendered.

*~INSURANCE~*

Dental Insurance is a contract between you and your insurance carrier, not between the insurance carrier and this office. Insurance companies can take up to 90 days for claims to be paid. It is the responsibility of the patient/guardian to be aware of their plan limitations and waiting periods.

We assume no responsibility for what your insurance carrier *will* or will not pay. Please understand that there are many different benefit packages offered by numerous insurance companies and we cannot possibly know the details of each one. We will provide you with an *ESTIMATED* co- payment amount at the time services are rendered, however any remaining balance after your insurance company has paid, will be the responsibility of the patient/guardian.

All 'estimated payments' will be due at the time of service. For your convenience, we accept: Visa, Mastercard and Discover, in addition to cash, personal check and Care Credit.

Our office is committed to providing the best treatment for you, regardless of insurance coverage. Our treatment and fees remain the same whether a patient has insurance or not and we want to be flexible in these changing times and will do our best to make this work for everyone.

☐ I have read and agree with the policies stated above for The Smile PS

Patient/Guardian Signature: _____ Today's Date: _____

~FOR OFFICE USE ONLY~

We attempted to obtain written acknowledgment but could not be obtained because:

- ☐ Individual refused to sign
- ☐ Other – Please specify below
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

_____

_____

# DENTAL TREATMENT CONSENT FORM

## THE SMILE LEXINGTON

**Patients Name**_____(please Print)

**Please read and initial the marked lines below and read and sign at the bottom of form.**

- X-RAYS:_____X

- DRUGS AND MEDICATIONS: I 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)_____X

- 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 procedures. I give permission to the Dentist to make any/all changes and additions as necessary_____X

- REMOVAL OF TEETH: Alternatives to removal have been explained to me (root canal therapy, crowns, and perio surgery) 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, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand 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._____X

- DENTURES, COMPLETE OR PARTIAL: I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems or wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize that 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. 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._____X

- ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extent through the root, which does not necessary affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment._____X

- PERIODONTAL LOSS (TISSUE & BONE): I understand that care must be exercised in the area of debridement during the next several days. I understand that more extensive treatment may need to be performed, (full moth debridement, scaling and root planning). Medication may be placed or prescribed to reduce infection and prevent bone loss. Care of site is recommended as prescribed. Sensitivity is not uncommon or may occur. Additional treatment may be needed and not a covered expense._____x

- FILLINGS: I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling._____X

- DENTURES: I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. This is not included in the denture fee. I understand that it is my responsibility to return for the delivery. I understand that failure to keep my appointment may result in poorly fixed dentures._____X

- LASERS: I understand that any time teeth are manipulated, whether by a mechanical drill or laser, there is always the possibility and risk that root canal therapy may be necessary. I realize that, in spite of observing every reasonable precaution, prior nerve damage infection or tooth trauma may have existed in the tooth. I further understand that anytime that soft tissue is manipulated, whether by traditional technology or laser dentistry; there is always a possibility and risk of unexpected and undesirable side effects. I understand that high-technology dentistry, including laser therapy, may be considered "investigational" or "experimental" and may not be reimbursed by some insurance companies, and I must anticipate paying 100% for such treatment. I understand and this office is performing this treatment in my own best interest._____X

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee of assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to the best of my satisfaction. I consent to the proposed treatment.

SIGNATURE OF PATIENT/GUARDIAN IF PATIENT IS A MINOR

_____DATE_____