	Orange Smiles **Phone:**	

PATIENT REGISTRATION

Patient is : □ ***Responsible Party*** □ ***Policy Holder***

Patient Information:

First Name: _____ Last Name:_____ Middle Initial:____

Address: _____City, State, Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Birth date: _____ Social Security #: _____ DL:_____

Email address: _____ Sex: ○ Female ○ Male

Guardian's Name if Child: _____

D.O.B_____

Policy Holder Information

Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Name of Insured: _____ Member ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer Name :_____ Employer Address:_____

Insurance Company: _____

Emp. Phone Number: _____ Ins. Phone Number: _____

Medicaid/CHIP Information:

Plan Name: _____ Member ID: _____

Physician Name: _____ Phone Number: _____

How Did You Hear About Us?

☐ Google / Search Engine ☐ Facebook ☐ Direct Flyer

☐ Newspaper ☐ Billboard ☐Community / School Event

☐ Radio ☐ Doctor Friends / Family

☐ Drive By

Medical History

Patient Name _____ D.O.B. _____

Emergency Contact (Name/Phone Number) _____

Medical History

1. Physician_____Address _____

2.When was your last physical examination? _____

3. Are you under the care of a physician?..... ☐ Yes ☐ No

If yes, for what reason(s)? _____

4. Are you presently taking any medications/drugs/pills/herbals/supplements?..... ☐ Yes ☐ No

If yes, please list:_____

5. (Women) Is there a chance you are pregnant? ..... ☐ Yes ☐ No

If yes, anticipated due date?_____

6. Do you take oral contraceptives? ..... ☐ Yes ☐ No

7. Are you allergic/sensitive to: ☐None ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex ☐Pine Nuts ☐Dyes

☐ Other_____

8. Do you smoke, chew or use E-cigarettes? ..... ☐ Yes ☐ No

If yes, please indicate which one(s), daily frequency and how long?_____

9. Do you have Diabetes? ..... ☐ Yes ☐ No

If Yes, please indicate ..... ☐ Type 1 ☐ Type 2 Last HbA1c date and level_____

10. Do you have, or have you ever had:

Heart trouble	☐Yes ☐No	Excessive or prolonged bleeding	☐Yes ☐No
Heart murmur	☐Yes ☐No	Thyroid problem	☐Yes ☐No
Heart surgery	☐Yes ☐No	Jaundice	☐Yes ☐No
Heart pacemaker	☐Yes ☐No	Hepatitis(Type)	☐Yes ☐No
Rheumatic fever	☐Yes ☐No	Cancer	☐Yes ☐No
Congenital heart defects	☐Yes ☐No	Chemotherapy/radiation	☐Yes ☐No
Artificial heart valve/stent/graft	☐Yes ☐No	Arthritis	☐Yes ☐No
Abnormal blood pressure	☐Yes ☐No	Artificial joint replacements	☐Yes ☐No
Stroke	☐Yes ☐No	Cortico-Steroid treatment	☐Yes ☐No
Ulcers / GERD	☐Yes ☐No	Osteoporosis/treatment w/Bisphosphonates	☐Yes ☐No
Kidney trouble/Dialysis	☐Yes ☐No	HIV positive/AIDS	☐Yes ☐No
Tuberculosis or lung disease	☐Yes ☐No	Oral herpetic lesions	☐Yes ☐No
Asthma	☐Yes ☐No	Sexually Transmitted disease	☐Yes ☐No
Sinus trouble	☐Yes ☐No	Psychiatric care	☐Yes ☐No
Epilepsy / seizures	☐Yes ☐No	Glaucoma	☐Yes ☐No
Fainting spells	☐Yes ☐No	Hearing impaired	☐Yes ☐No
Anemia	☐Yes ☐No	Chemical dependency	☐Yes ☐No
Leukemia	☐Yes ☐No	Do you take pre-medication for anything	☐Yes ☐No
		If you pre-medicate for what	_____

11. Have you had any other serious illness, hospitalization or accident? ☐Yes ☐No

If yes, please explain:_____

Financial Policy Consent Form

You need to be aware that:

1. Your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.
2. Your treatment plan is individually tailored and is not based on your dental insurance benefits or lack of benefits.
3. We will give you an estimated treatment plan prior to the appointment. We do not know all the limitations and downgrades that each plan may have. However, parents must understand: We are only estimating insurance benefits; you are responsible for payment of any amounts the insurance does not cover, for whatever the reason.
4. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
5. **It is your responsibility to thoroughly understand the coverage and exceptions of your policy.**
6. As a courtesy to all our insured patients, we will file your dental insurance claim forms. In special circumstances, an insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion.
7. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately, and benefits are expected are to be paid within 30-45 days. The filling of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any other amounts your insurance company chooses not to pay for whatever reason.

Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail. I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction.

I _____ hereby authorize my insurance benefits to be paid directly to **Orange Smiles**. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether paid by said insurance, and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient/Legal Guardian Signature: _____ Date: _____

Staff Initial: _____

Appointment Policy

A cancellation fee of $15.00 will be issued for any failed appointments without a 24-hour notice.

MEDICAID

MCNA DENTAL & DENTAQUEST are notified through our automated system if you cancel or no show for your appointment. In order to keep your insurance active, you must follow your insurance company's policy.

Patient/Legal Guardian Signature:_____ Date:_____

If you may have any questions or concerns, please feel free to contact our business manager.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

Name:_____

DOB:

Patient Name (Please Print)

_____

Patient Signature Date:_____

OR

Signature of Personal Representative_____

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other:

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___A communication barrier prevented us from obtaining acknowledgement.

___The individual was unwilling to sign.

Other:_____

_____ _____

Staff Member Signature Date

Informed Consent for Dental Treatment

Patient Name: _____ Date of Birth _____

X-rays:

Proposed treatment: the taking of intraoral (inside the mouth) and extraoral (outside the mouth) radiographs.

Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development, and eruption of teeth. They are also necessary for proper diagnosis and evaluation purposes.

Alternatives to treatment: none; limited visual examination.

Common Risks: minimal radiation exposure to soft and hard tissues of the head.

I have read and understood the entire information on this consent form, which includes x-rays, All my questions were answered to my full understanding and satisfaction.t

_____	_____
Patient/ Parent / Guardian Printed Name	Relationship to Patient
_____	_____
Patient/ Parent/ Guardian Signature	Date
_____	_____
Witness Printed Name	Witness Signature