Lifetime Smiles

***Lifetime Smiles** is committed to providing you with the best dental care available. We have found that a clear understanding of our office financial guidelines relieve some of the anxiety associated with going to the dentist. We want to be certain that our guidelines are clear and that all of your questions are answered to your satisfaction. For your convenience we honor several different payment plans.*

Payment Options:
When you do not have dental insurance, we ask that you pay for your dental services in full at the end of each appointment. We gladly accept Cash, MasterCard, Visa, Discover and American Express. We also offer Dental Health Discount Plan for those without insurance as an added value to you.

Dental Insurance:
As a courtesy we will file your insurance claim for you. We will make a good faith estimate for planned treatment and request that you pay your estimated portion at the time of service. When payment has been received from your insurance carrier, we will settle the outstanding balance of your account with you (there may be a difference between the estimated portion and actual payment). As a service to you, we will complete and file the appropriate claim forms with your insurance carrier(s). We are happy to provide any x-rays or additional information they might require. If your insurer denies coverage or delays payment beyond 60 days from the claim filing date, the entire amount will become due and payable by you. Although we make every effort to help you obtain your full benefit, there are many variables we cannot anticipate nor control. Please be aware that your insurance benefits are a contract between you, your employer (if applicable) and insurance company.

Financial Services:
We offer Care Credit service that allows you to pay over time with convenient monthly payments. For more information please inquire with the front office staff.

We Would Also Like You to Know:
• Our office requires a minimum of 2 business days notice (longer if possible) if you are unable to keep your reserved appointment time.
• YOUR APPOINTMENT IS SPECIFICALLY RESERVED FOR YOU. A fee of $50 per hour of missed appointment time will be charged to the patient for any appointment that is canceled without at least two business days' notice.
• There will be a $25.00 charge for unpaid returned checks.

I authorize payment to be made directly to Lifetime Smiles by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical information requested by my insurance carrier. I agree to pay interest of 1.5% (18% annually) on any balance over 30 days. I hereby agree that in the event of default of any amount due, and if this account is placed with a collection agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including any attorney fees and court costs incurred and permitted by laws governing these transactions up to 50% of the family's total balance.

SIGNATURE OF PATIENT / GUARDIAN

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Patient/Parent or Guardian	Signature Printed	Name Date

Lifetime Smiles

Patient Information

Patient Name:____________________________ Preferred Name:___________________________

Address:_________________________________ City:___________State:_________Zip:_________

CellPhone:_______________________________ HomePhone:______________________________

Email:___________________________________ Married______ Single______ Child_________

Gender:________Age:____Date of Birth______ Social Security #:_________________________

ReferredBy:_______________________________Employer:_________________________________

Occupation:_______________________________Work Phone:______________________________

Emergency Contact:_______________________ Phone:__________________________________

Parent/Guardian Information (If under the age of 18)

Parent/Guardian Name:__________________ Relationship to child:________________________

Address:_________________________________City:__________State:________Zip:___________

Cell Phone:_______________________________Home Phone:_______________________________

Gender:_____Age:_____Date of Birth:________Social Security #:__________________________

Employer:_________________________________Occupation:______________________________

Work Address:____________________________ WorkPhone________________________________

Insurance Information

Primary Insured (Subscriber):_________________Relationship to Patient:______________________

Date of Birth:_____________________________Subscriber ID#:______________________________

Insurance Company:_______________________Group #____________________________________

Subscriber Employer or Plan Sponsor:____

Additional Insurance

Primary Insured (Subscriber):________________ Relationship to Patient:______________________

Date of Birth:______________________________SubscriberID#:_______________________________

Subscriber Employer or Plan Sponsor____

Insurance Company:____

Authorization and Release

I authorize my insurance company to pay Lifetime Smiles all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** Lifetime Smiles may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA .

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Patient/Parent or Guardian Signature **Printed Name** **Date**

Dental History

Reason for today's visit: ____________________

How often do you brush? ____________________ How often do you floss? ____________________

Approx date of last dental visit: ____________________

Please mark all that apply:

- ☐ TOOTHACHE
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN FILLINGS
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN TEETH
- ☐ FOOD CATCHES
- ☐ FLOSSING BREAKS OR HURTS
- ☐ PAIN, CLICKING OR POPPING OF JAW
- ☐ GRINDING OF TEETH
- ☐ CLENCHING OF JAW
- ☐ HEAD ACHES
- ☐ SNORING / SLEEP APNEA
- ☐ SENSITIVITY
  - ☐ COLD
  - ☐ HOT
  - ☐ SWEET
  - ☐ CHEWING
  - ☐ TOUCH
- ☐ SINUS PROBLEM
- ☐ GAGGING
- ☐ DRY MOUTH
- ☐ DARK OR WHITE SPOTS ON TEETH
- ☐ GUMS
  - ☐ BLEEDING
  - ☐ TENDER OR SORE
- ☐ LOOSE TEETH
- ☐ TEETH HAVE SHIFTED
- ☐ BAD BREATH
- ☐ BAD TASTE IN MOUTH
- ☐ SORES OR GROWTHS IN MOUTH
- ☐ OTHER ____________________

Medical History

Please mark all that apply:

Have you been: ☐ Hospitalized? ☐ Are You Taking Medication? ☐ Do You Have Allergies?

Please describe: ____________________

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YES	NO	
☐	☐	*PRE-MED - AMOX
☐	☐	*PRE-MED-CLIND
☐	☐	*PRE-MED-OTHER____________________
☐	☐	ALLERGY - ASPIRIN
☐	☐	ALLERGY - CODEINE
☐	☐	ALLERGY - ERYTHRO
☐	☐	ALLERGY - HAY FEVER
☐	☐	ALLERGY - LATEX
☐	☐	ALLERGY - PENICILLIN
☐	☐	ALLERGY - SULFA
☐	☐	ALLERGY - OTHER____________________
☐	☐	ANEMIA
☐	☐	ARTHRITIS
☐	☐	ARTIFICIAL HEART VALVE
☐	☐	ARTIFICIAL JOINTS
☐	☐	ASTHMA
☐	☐	BACK PROBLEMS
☐	☐	BIPHOSPHATE MEDS (FosaMax, Acetol, Atelviz, Didronel, Boniva)
☐	☐	BLEEDING DISORDERS
☐	☐	BLOOD THINNERS
☐	☐	BLOOD DISEASE
☐	☐	BLOOD TRANSFUSION
☐	☐	CANCER____________________
☐	☐	CHEMICAL / DRUG DEPENDENCIES
☐	☐	CHEMO THERAPY
☐	☐	CIRCULATORY PROBLEMS
☐	☐	CORTISONE TREATMENT
☐	☐	DIABETES
☐	☐	DIZZINESS
☐	☐	EPILEPSY
☐	☐	FAINTING
☐	☐	GLAUCOMA
☐	☐	HEAD INJURIES
☐	☐	HEART DISEASE
☐	☐	HEART MURMUR
☐	☐	HEART PROBLEMS
☐	☐	HEMOPHILIA
☐	☐	HEPATITIS
☐	☐	HIGH BLOOD PRESSURE
☐	☐	HIV
☐	☐	JAUNDICE
☐	☐	KIDNEY DISEASE
☐	☐	LIVER DISEASE
☐	☐	MARIJUANA USAGE
☐	☐	MENTAL DISORDERS
☐	☐	MITRAL VALVE PROLAP
☐	☐	NERVOUS DISORDERS
☐	☐	NURSING
☐	☐	PACEMAKER
☐	☐	PERSISTENT COUGH
☐	☐	PREGNANT
☐	☐	RADIATION TREATMENT
☐	☐	RESPIRATORY PROBLEMS
☐	☐	RHEUMATIC FEVER
☐	☐	SCARLET FEVER
☐	☐	SHORTNESS OF BREATH
☐	☐	STROKE
☐	☐	SWELLING FEET / ANKLE
☐	☐	TAKING BIRTH CONTROL
☐	☐	THYROID CONDITION
☐	☐	TOBACCO USAGE
☐	☐	TONSILLITIS
☐	☐	TUBERCULOSIS
☐	☐	ULCERS
☐	☐	VENEREAL DISEASE
☐	☐	OTHER____________________

Physicians Name: ____________________ Phone: ____________________

Pharmacy Name: ____________________ Phone: ____________________

In Office Use

HEAD & NECK EXAM	WNL or : ____________________
SOFT TISSUE	WNL or : ____________________
TMJ EXAM	WNL or : ____________________
OCCLUSION	CLASS I II II
ORTHO	☐ YES ☐ NO

In Office Notes

To the best of my knowledge the above information is accurate and complete. I will not hold the doctor or any members of their staff responsible for any errors or omissions I may have made in the completion of this form.

PATIENT / GUARDIAN SIGNATURE ____________________ PRINTED NAME ____________________ DATE ____________________

DR.'S SIGNATURE ____________________ DATE ____________________