All Smiles Dental Care

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Welcome to All Smiles Dental Care!

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI)

_____ Preferred Name

Title: _____ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____

Best time to call: _____

Phone: _____ Home _____ Mobile _____ Work _____ Ext

_____ Fax _____ Other

Address: _____ Address 1

_____ Address 2

_____ City _____ State _____-____ Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____

Phone: _____

Employer Address: _____ Address 1

_____ Address 2

_____ City

_____ State _____-____ Zip Code

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Whom may we thank for referring you to our team?

Dental History

Dental Experiences: Check all that apply.

- ☐ Had an unfavorable dental experience
- ☐ Had your teeth whitened/bleached
- ☐ Had/have dental anxiety (fear)
- ☐ Had orthodontic treatment(or braces)
- ☐ Had complications with past dental treatment
- ☐ Had any appliances or retainers
- ☐ Had trouble getting numb
- ☐ Had any teeth removed
- ☐ Had a reaction to local anesthetic
- ☐ Had teeth replaced (implants/partials)
- ☐ Have taken antibiotic premedication
- ☐ Had jaw or sleep apnea treatments
- ☐ Had your bite adjusted many times
- ☐ Had botox or derma filler treatments

What is your immediate dental concern or request?

_____

_____

Previous dental office name:

_____

_____

Date of last visit in their office:

_____

_____

You were seeing your previous dental team for routine care every:

☐ 3 mo. ☐ 6 mo. ☐ 12 mo. ☐ Rare ☐ Never

Tooth Structure: Check all that apply.

- ☐ Had cavities within past 3 years
- ☐ Have a dry mouth
- ☐ Have difficulty swallowing
- ☐ Have broken/fractured teeth
- ☐ Have cold or hot sensitivity
- ☐ Have biting senstivity
- ☐ Get food caught in your teeth

Gingiva and Bone: Check all that apply.

- ☐ Have blood when brushing or flossing
- ☐ Diagnosed with gum/periodontal disease
- ☐ Had gum/periodontal disease treated
- ☐ History of periodontal disease in your family
- ☐ Notice an unpleasant taste or odor
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth

Occlusion and Joint: Check all that apply.

- ☐ Problems with my jaw hurting
- ☐ Problems chewing food
- ☐ Teeth are short, thin or worn
- ☐ Teeth are crowding or developing spaces
- ☐ Chew ice or bite your nails
- ☐ Wake up with headaches
- ☐ Jaw tires as the day longs
- ☐ Bite changes all the time

Smile Characteristics: Check all that apply.

- ☐ Is there anything about the appearance of your teeth that you would like to change?
- ☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
- ☐ Have you been disappointed with the appearance of previous dental work?

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ * **I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I understand the dental practice cannot and does not assume any responsibility for my use or misuse of patient information or other information transmitted, monitored, stores, uploaded or received using the site or the services.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

All Smiles Office Policies

PATIENT INFORMATION
It is our policy that we update your medical history at each appointment. Please bring an updated medication list with you. Please notify us of any changes. Patient information packets are typically updated every five years at the same time as your comprehensive exams. This will soon be available to do on our website for you to fill out prior to your appointment to save you time if you prefer.

HIPAA Policy
We value your health information and we do everything possible to protect your personal information. HIPAA provides protection of your health information.

APPOINTMENT COMMITMENT
We value your time and ask that you value ours as well. Therefore, we try to make our schedule predictable! If you are late, you may have to be rescheduled or wait until we are available. If you are unable to make it on the day and time you had reserved, we ask for a 48 hour notice so we may offer that time to other patients. If you have received an appointment commitment letter from us for repeated scheduling conflicts, you are required to confirm your appointment within 48 hours or it will be removed from the schedule.

COURTESY CONFIRMATIONS
With our new software we will be able to sync email and text confirmations if you choose. Our team can continue to phone as well. Please be sure to let us know your preference.

MISSED APPOINTMENTS
Missed appointments result in an inability to provide care to others who could have been seen in that time and increase the cost of care for others. We understand that life happens, but we ask that you call us as soon as you realize there is a conflict. Multiple last minute missed appointments will result in a dismissal from our practice.

INSURANCE
We accept all insurance plans and contracted providers with Delta Dental, Blue Cross Blue Shield of Kansas and the Sunflower KanCare program. If you need help in determining what your plan covers our team is here to assist you or you can call the number on the back of your insurance card. Insurances give estimates and not guarantees.

RETURNED CHECKS
Checks returned as "Insufficient Funds" will be assessed a $30 service charge in addition to being contacted for payment in cash or a money order.

LAB CHARGES
All orders that require the use of an outside lab, such as crowns, dentures or appliances, require a minimum 50% deposit before they will be processed and the balance is due in full upon delivery since they are custom made.

BILLING STATEMENTS
Statements will be mailed every Friday for the treatment completed that week and will be due in twenty days. You will only receive one if you have not in the last 30 days. If an insurance claim is processing, the insurance estimate will show on your statement along with your patient portion separate. Every quarter, we assess credits and refund patients accordingly if insurance has closed.

FINANCE CHARGES & PAST DUE ACCOUNTS
A 10% finance charge is assessed on delinquent accounts over 60 days. Accounts 120 days past due will be transferred to our collection agency for legal action.

MINOR CHILDREN
If a minor child comes alone for an appointment, it is required the parent is easily and readily available by phone for verbal permission of treatment. If a minor child comes alone for an appointment, call ahead to arrange any payment for services and have their patient information paperwork done prior.

DIVORCED PARENTS
The person who brings a minor child to an appointment is responsible for paying for the services. Please understand, we cannot be responsible for collecting partial payments form another individual. Any court ordered agreement is between the divorced parties.

☐ * **I acknowledge that I have read All Smiles Dental Care's office policies and know that in order to receive optimal care as a patient that I must choose compliance.**

Primary Dental Insurance:

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City

State Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State Zip Code

Insurance Authorization:

☐

I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City

State Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State Zip Code

Insurance Authorization:

☐

I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Response Date: