PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name_____
Last First Middle

Address _____
Street City Zip

Nickname_____ Birthdate_____ Social Security # _____

School_____ Sports/Hobbies_____

Parent or guardian name _____

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

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Previous Address (If less than 3 years) _____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Has menstruation started? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school hours? _____

Signature: _____ Date: _____

FINANCIAL POLICY CONSENT FORM

We welcome you and your family to Classic smiles LLC. We look forward to providing you with quality dental care. To provide you with the most beneficial and comprehensive service and care, we request you review and complete our office and financial policy consent forms. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your dental treatment.

Dental Insurance benefits: You need to be aware that:

We will always do our best to help you to maximize your benefits. Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Your treatment plan is individually tailored and is not based on your dental insurance benefits or lack of benefits. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

It is your responsibility to thoroughly understand the coverage and exceptions of your policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

Dental Insurance Claim Payments:

As a courtesy to all of our insured patients, we will file your dental insurance claim forms. In special circumstances, a particular insurance company's benefit check can be sent to you directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your coinsurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly. Your claim will be filed immediately, and benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 45 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 amounts your insurance company chooses not to pay for whatever reason.

I _____ understand and accept the financial and insurance policies listed above and have had any and all questions answered to my satisfaction.

I_____ agree to pay for all treatment in a timely fashion as described

I _____ hereby authorize my insurance benefits to be paid directly to Classic smiles LLC. I realize that I am responsible for paying any deductible amount(s), my co-insurance portion and noncovered services that Classic smiles LLC is made aware of by my Dental carrier. I understand that I am financially responsible for all charges of dental treatment and fees incurred, whether paid by said insurance. I agree to pay such charges in full.

Cancellation less than 48 hours and or same day cancellation results in a $75.00 per half hour charge.

Co-insurance will not be billed by this office.

PAYMENT OPTIONS AVAILABLE

: All Major Credit and Debit Cards

: Cash/ Cashier Checks

: Cherry / alphaeon