

CITY SMILES

general & aesthetic dentistry

WELCOME TO OUR PRACTICE

PATIENT

	Last Name	First Name	Middle Initial	Preferred Name
Street Address _____		City _____	State _____	ZIP _____
Cell Phone _____		Home Phone _____		Email _____
Sex: _____	Birthday _____	Social Security # _____		Marital Status _____
Employer _____		Work Phone _____		Occupation _____
In case of emergency, who should be notified? _____				Phone _____

RESPONSIBLE PARTY

(If parent or guardian)

	Last Name	First Name	Middle Initial
Street Address _____		City _____	State _____ ZIP _____
Cell Phone _____		Home Phone _____	
Email _____	Sex: _____	Birthday _____	Social Security # _____
Marital Status _____		Employer _____	
Work Phone _____		Occupation _____	

REFERRAL SOURCES

Please let us know who referred you to us or how you heard about our practice. As a special thanks to our patients, we will credit \$25 to their account for each patient referred. *Referral source or patient name:* _____

DENTAL INSURANCE INFORMATION

Name of Insured _____			
	Last Name	First Name	Middle Initial
Birthday _____	Social Security # _____		Employer _____
Insurance Carrier _____		Phone # _____	Group # _____

MEDICAL INSURANCE INFORMATION

Name of Insured _____			
	Last Name	First Name	Middle Initial
Birthday _____	Social Security # _____		Employer _____
Insurance Carrier _____		Phone # _____	Group # _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ (Name of Minor/Child) do hereby request and authorize the dental staff to perform necessary services for my child, including but not limited to X-rays, and an administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Patient, Parent or Guardian Signature _____ **Date:** _____
 (Must be 18 years or older to sign)

STAFF USE ONLY

Photo ID Verified	ID#/Type	State	Exp. Date
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DENTAL HISTORY AND CONCERNS

City Smiles focuses on providing comprehensive care to adults and their families. We are able to deliver care that not only improves our patient's health and aesthetics but also changes their lives. We look beyond just the teeth and gums, treating the whole patient, comprehensively. We seek to establish a harmonious relationship of the three main factors affecting your bite—teeth, muscles, and jaw joints. An optimal bite is also essential to ensure that smile makeovers and dental restorations are beautiful, functional, and long-lasting.

What is your chief complaint? _____

Does floss shred when you use it? **Yes No** Does food pack or catch between your teeth? **Yes No**

Do you smoke or chew tobacco? **Yes No** Do your gums bleed? **Yes No** Does your breath concern you? **Yes No**

Are you interested in learning how we may be able to straighten your teeth in just 6 months? **Yes No**

When was your last dental appointment and cleaning? _____

How would you rate your smile? **(Lowest) 1 2 3 4 5 6 7 8 9 10 (Highest)**

Should you need treatment, at what point should we address it?

- When my tooth hurts or breaks When something is worsening Before problem occurs

Please indicate if you have any of the following concerns (check all that apply):

- My teeth are not in alignment I have spaces I don't like I do not like the color of my teeth
 Chipped Teeth Protruding teeth Hidden or missing teeth
 Old Fillings, Veneers, or Crowns TMJ Disorder Overall appearance of my smile

Have you ever been told or are you aware that you snore? **Yes No**

Have you completed or ever been recommended a sleep study? **Yes No**

Are you interested in sedation or nitrous? **Yes No**

What is the reason for trying a new dental office? _____

Are there any additional concerns you would like us to know? _____

MEDICAL HISTORY

Although as dentists we treat the area in and around the mouth, it is a part of your entire body. Medical health problems that you may have, or medications that you may be taking, could be important to your dental health. Thank you for **thoroughly** answering the following questions.

Family Physician _____ Phone # _____

Are you taking any medication now, including regular dosages of aspirin? **Yes No**

If so, please list name and dosage _____

Are you aware of having an allergic reaction to any medication or substance? **Yes No**

If so, please list (e.g. Latex, penicillin, iodine) _____

Have you been under the care of a medical doctor during the past two years? **Yes No**

If so, for what? _____

Have you ever had heart surgery, heart valve or joint replacement, or organ transplant? **Yes No**

If so, for what and when? _____

Do you require premedication (e.g. knee replacement)? **Yes No** If so, for what? _____

Do you or have you **ever** taken Fosamax or any other biphosphonate, Zometa, Aredia, Boniva, or Actonel? **Yes No**

Women: Are you Pregnant? Nursing? Taking Birth Control Pills?

Have you seen an ENT (ear, nose, and throat doctor)? **Yes No** Name _____

Have you seen a neurologist? **Yes No** Name _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Concerns	Yes No	Neurological Disorders	Yes No	Headaches	Yes No
Congenital Heart Disease	Yes No	Osteoporosis	Yes No	Limited Mouth Opening	Yes No
Heart Murmur	Yes No	Liver Disease/jaundice	Yes No	Ringing Ears	Yes No
High Blood Pressure	Yes No	Sickle Cell Disease	Yes No	Facial Pain	Yes No
Mitral Valve Prolapse	Yes No	Asthma	Yes No	Sensitive Teeth (Hot/cold)	Yes No
Artificial Heart Valve	Yes No	AIDS/HIV	Yes No	Difficulty Swallowing	Yes No
Pacemaker	Yes No	Stroke	Yes No	Tingling in arms/fingers	Yes No
Latex Allergy	Yes No	Angina	Yes No	Jaw Clicking/Popping	Yes No
Artificial Joints	Yes No	Anemia	Yes No	Dizziness	Yes No
Kidney Trouble	Yes No	Ulcers	Yes No	Posture Problems	Yes No
Radiation/Chemotherapy	Yes No	Tuberculosis	Yes No	Trigeminal Neuralgia	Yes No
Epilepsy/Seizures	Yes No	Arthritis	Yes No	Bell's Palsy	Yes No
Hepatitis	Yes No	Difficulty Chewing	Yes No	Jaw Pain	Yes No
Psychiatric Disorders	Yes No	Insomnia/Nervousness	Yes No	Congested Ears	Yes No
Diabetes	Yes No	Teeth Clenching/Grinding	Yes No	Loose Teeth	Yes No
Thyroid Disorder	Yes No	Snoring / Sleep Apnea	Yes No	Neck Ache	Yes No

Notes/Any other health issues _____

Medical updates _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify City Smiles doctors' of any change in any health or medication.

Patient, Parent or Guardian Signature _____ **Date:** _____

FINANCIAL POLICY / PAYMENT OPTIONS

Our mission is to deliver the best and most comprehensive dental care, and financial considerations should not be an obstacle in fulfilling your needs. Therefore we provide a range of payment options for our patients.

CHECK, DEBIT CARD, VISA, MASTERCARD, DISCOVER CARD, OR AMERICAN EXPRESS

A 5% courtesy discount is given to patients who pay in full for their treatment with cash, check, or debit card prior to completion of care for treatment plans in excess of \$1,000. This does not apply when assigning insurance benefit.

DENTAL PAYMENT PLAN (Monthly payment plans including no-interest and extended period plans)

Flexible monthly payment plans are available for treatments over \$1000 from the third party companies Springstone and Citi Financial ("The Financing Companies"), subject to credit approval. We are able, in many instances, to obtain credit approval even if you have a limited or negative credit history.

Credit Check Permission: If you are interested in paying for treatment in monthly installments, please initial below to give your authorization to City Smiles and the Financing Companies to check your credit history as necessary for the purpose of obtaining and maintaining your credit. **Initials** _____

INSURANCE PLANS

We accept most dental plans and we will work to maximize your dental benefits and submit your insurance claims at no charge. For your convenience, we accept the insurance benefit directly from your insurance company, and only the estimated portion not covered by your insurance is due at the time treatment is performed. However, we make no guarantees of your insurance reimbursement, and if we do not receive payment in full from your insurance company within 60 days, you will be responsible for the unpaid insurance portion.

Assignment and Release: You, the undersigned, assign directly to City Smiles, all benefits, if any, otherwise payable to you for services rendered. You hereby authorize the doctor to release all information necessary to secure the payment of benefits. You authorize the use of your signature on all your insurance submissions whether manual or electronic. In order for City Smiles to accept assignment of benefits, we require a credit card on file with our office to cover any unpaid balance not covered by your insurance company. If you choose not to have a credit card on file, we expect full payment, by the patient, at time of service, unless other financial arrangements have been made. We will, then, have your insurance company reimburse you directly.

FLEXIBLE SPENDING ACCOUNTS

If you work for a company that provides a flexible spending account, or a "flex-plan," we will explain to you the mechanism for saving up to 35% on your treatment cost by paying with non-taxable income.

PLEASE NOTE

We require payment or a financial arrangement before the start of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Your appointments have been reserved exclusively for you. If you are unable to come for your appointment, *please notify our staff 48 hours in advance* so that we may offer that availability to another patient in need of treatment.

For your protection, and to constantly improve the quality of care we deliver, phone calls to our office may be recorded.

A late charge of \$5.00 or 1.5% per month will be applied to unpaid balances. There will be a \$25 charge for all returned checks.

I have read the Financial Policy in its entirety and I understand and agree to all its terms.

Patient, Parent or Guardian Signature _____ **Date:** _____
(Must be 18 years or older to sign)