Welcome To Smiles By Eddie

SMILES By Eddie

Thank You for Selecting Our Dental Team.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____

SS#/SIN _____ Birth-date _____ Home Phone _____

Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____

How did you hear about us? ☐ Yelp ☐ Google ☐ Referral _____ ☐ Other _____

Person to Contact In Case of Emergency _____

Responsible Party

First Name _____ Middle Name _____ Last Name _____

Street _____ Zip _____ City _____ State _____ Country _____

Date of Birth _____ Sex ☐ Female ☐ Male ☐ Unspecified

Responsible Party Signature _____ Date _____

Preferred Pharmacy

Name _____ Phone Number _____

Street _____ Zip _____ City _____ State _____

Primary Dental Insurance

Is the subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name _____ Middle Name _____ Last Name _____

Employer name _____ Insurance Company _____

Ins Phone Number _____

Subscriber ID/Policy No. _____ Group/Contract Number _____ Date of Birth _____

Patient Relationship to Subscriber ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN _____

Secondary Dental Insurance

Is the subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name _____ Middle Name _____ Last Name _____

Employer name _____ Insurance Company _____

Ins Phone Number _____

Subscriber ID/Policy No. _____ Group/Contract Number _____ Date of Birth _____

Patient Relationship to Subscriber ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN _____

Smile With Confidence

SMILES *By Eddie*

Patient Medical History

Physician _____ **Office Phone** _____ **Date of Last Exam** _____

	Yes	No
1. Are you under medical Treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, Please explain_____		
3. Are you taking any medication(s) including non-perscription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anaesthetics (e.g. Novocain)	☐	☐
Penicillin or any other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other_____	☐	☐

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Osteoporosis	☐	☐
Other_____							☐	☐

Patient Dental History

Name of Previous Dentist and Location_____ **Date of Last Exam** _____

	Yes	No
1. Do your gums bleeds while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking	☐	☐
b) Pain (joint, ear, side of face)	☐	☐
c) Difficulty in opening or closing	☐	☐
d) Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Do you like your smile?	☐	☐

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentists to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____ **Signature** _____ **Date** _____

Payment, Insurance and Financial Arrangement Policies (signed by ALL new patients)

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature_____ **Date**_____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party Section.)

Notice of Privacy Practices (must be signed by ALL new patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature_____ **Date**_____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party Section.)

I certify that I have read and understood the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature _____ **Date** _____

Dr's Signature/Medical History Review _____ **Date** _____

6 MONTH UPDATE

Patient's Signature _____ **Date** _____

Dr's Signature/Medical History Review _____ **Date** _____

SMILES By Eddie

Consent for Services and Financial Policy

Thank you for choosing us as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. All patients must read and sign this form before seeing the doctor. As a condition of your treatment by our office, financial arrangements must be made in advance. Our practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, and CARE CREDIT.

DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your treatment costs. Therefore, you will be expected to pay your **deductible** and your **estimated co-payment** on the day the services are rendered. We will gladly file your insurance claim as a courtesy. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions): therefore, **we cannot guarantee any estimated charges**. Your policy and benefits are an agreement between you and the insurance company so ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. ***We will gladly file all dental claims for any given treatment but we are not party to any insurance programs or contracts. The balance is YOUR RESPONSIBILTY whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage.***

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER: All ESTIMATED portions and deductibles are due prior to treatment. In the event

your insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

TREATMENT PLAN ESTIMATES: We prepare TREATMENT PLAN ESTIMATES so that patients can understand their estimated cost of recommended restorative treatment prior to start. This Estimate is a good-faith attempt to predict the cost of your treatment based on the known facts when estimate is made. As your treatment progresses, your dentist may determine in consultation with you that **additional or a change in treatment may be necessary and that would change the estimated cost.**

USUAL AND CUSTOMARY RATES: Our practice is committed in providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates

ADULT PATIENTS: Adult patients are responsible for full payment at time of services rendered.

MINOR PATIENTS: The adult accompanying a minor and the parents/guardians of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa, Mastercard, American Express, Discover, Care Credit, Cash or Check at the time services are rendered.

NSF CHECK POLICY AND COLLECTIONS: Payments made by check that are not honored by the bank will incur a returned check fee of $50.00. The payment will be reversed from the appropriate account when a check is returned by the bank which could result in additional fees being assed to the account. A collection letter will be sent to the account holder notifying them of the returned item and outlining the consequences of not honoring the item within 10 business days. Returned check reimbursement payments must be in the form of cash, cashier's check, certified funds or money order. If you have a balance on your account that is past 90 days the account holder will be referred to collection agency for payment.

ASSIGNMENT OF INSURANCE BENEFITS: I understand that services rendered to me by Dr. Edmond Ahdoot, DDS, Associate Dentist, Specialist and/or Hygienist (collectively labeled as "Provider") are my financial responsibility and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Provider. I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to

facilitate the prompt payment of the claim by 25 days (electronically filed) or 45 days (paper mailed).

I authorized the provider to release any information necessary to adjudicate the claim and understand that there might be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should my insurance company send payment to me, I will forward the payment to the Provider within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event Patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or other payment to Provider. Any violations of this agreement will, at Provider's election, terminate Patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners.

I grant my permission to you or your assignee, to telephone me at home, my work, or my cell phone to discuss matters related to this form. I agree to have any photos taken of me to be used for education, training and/or marketing. I have read the above conditions of treatment and payment and agree to the contents.

_____ Date: _____

Printed Patient Name

_____

Signature of Patient

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By Eddie

Appointment cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Fee Policy** that allows us to schedule appointments for all patients. When Specialty, Hygiene, Restorative appointment is scheduled, that time has been set aside for you and when it is missed , that time cannot be used to treat another patient.

Our Policy as follows

We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$75.00** dollars or **$150.00** for Specialty will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$50.00** or **$150.00** for Specialty appointment will be charged. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for you patronage.

I have read and understand the appointment cancellation policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice .

Signature _____ Date _____