Gilbert Smiles
Family & Cosmetic Dental Care

PATIENT REGISTRATION

Date: _____

Patient Information:

First Name: _____Last: _____MI:_____ Preferred Name: _____

Address: _____ City: _____ ST: _____ Zip:_____

Cell Phone: _____ Work Phone: _____ Ext:_____ Hm. Phone: _____

Gender: ☐ Female ☐ Male Marital status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Birth Date: _____ Age: _____ SS#: _____ Drivers Lic: _____

Email: _____ Employer: _____

Who should we contact in case of emergency: _____ Relationship: _____Phone: _____

Responsible Party (if different than patient):

First Name: _____ Last: _____ MI: _____ Preferred Name: _____

Birth Date: _____ Age: _____ SS#: _____ Drivers Lic: _____

Address: _____ City: _____ St: _____ Zip:_____

Cell Phone: _____ Work Phone: _____ Ext:_____ Hm. Phone: _____

Email: _____ Employer: _____

Fill Out If Insurance Will Be Billed

Primary Insurance Information:

Subscriber Name: _____

Date of Birth: _____

Relationship to Subscriber: Self Spouse Child Other

Subscriber SS#: _____

Employer: _____

Insurance Company: _____

Member ID#: _____

Group #: _____

Secondary Insurance Information:

Subscriber Name: _____

Date of Birth: _____

Relationship to Subscriber: Self Spouse Child Other

Subscriber SS#: _____

Employer: _____

Insurance Company: _____

Member ID#: _____

Group #: _____

WHOM MAY WE THANK FOR REFERRING YOU/HOW DID YOU HEAR ABOUT US? _____

MEDICAL AND DENTAL HISTORY INFORMATION

Date: _____

Dental History:

Last Dental Visit: _____ Reason for today's visit_____

How often do you brush your teeth? _____ How often do you floss? _____

Do your gums bleed when you brush? Yes No

Do you have problems with bad breath? Yes No

Have you ever had an oral cancer screening? Yes No

Do you snore? Yes No

Have you or family member been treated for periodontal disease? Yes No

Have you ever had a popping or clicking near your ear when you chew? Yes No

Have you ever had complications from an extraction? Yes No

Are you prone to frequent headaches? Yes No

Do you have sores, blisters or swelling on your gums, lips or cheeks? Yes No

Have you ever had an allergic reaction to a crown or a metal filling? Yes No

Do you grind or clench your teeth? Yes No

Are your teeth sensitive to hot, cold or pressure? Yes No

Have you ever used an electric toothbrush? Yes No

Have you ever had orthodontic treatment? Yes No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be: _____

Medical History:

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Renal Dialysis Yes No
Alzheimer's disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Rheumatic Fever Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Rheumatism Yes No
Anemia Yes No	Easily Winded Yes No	High Blood Pressure Yes No	Scarlet Fever Yes No
Angina Yes No	Emphysema Yes No	High Cholesterol Yes No	Shingles Yes No
Arthritis/Gout Yes No	Epilepsy/Seizures Yes No	Hives or Rash Yes No	Sickle Cell Disease Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hypoglycemia Yes No	Sinus Trouble Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Irregular Heartbeat Yes No	Spina Bifida Yes No
Asthma Yes No	Fainting Spells Yes No	Kidney Problems Yes No	Stomach/Intestinal Disease Yes No
Blood Disease Yes No	Frequent Cough Yes No	Leukemia Yes No	Stroke Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Liver Disease Yes No	Swelling of Limbs Yes No
Breathing Problem Yes No	Frequent Headaches Yes No	Low Blood Pressure Yes No	Thyroid Disease Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Lung Disease Yes No	Tonsillitis Yes No
Cancer Yes No	Glaucoma Yes No	Mitral Valve Prolapse Yes No	Tuberculosis Yes No
Chemotherapy Yes No	Hay Fever Yes No	Osteoporosis Yes No	Tumors of Growths Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Pain in Jaw Joint Yes No	Ulcers Yes No
Cold Sores Yes No	Heart Murmur Yes No	Parathyroid Disease Yes No	Venereal Disease Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Psychiatric Care Yes No	Yellow Jaundice Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Radiation Treatment Yes No	
		Recent Weight Loss Yes No	

Are you under a physician's care now? Yes No Physician's Name & Number: _____

Have you been hospitalized or had major operation? Yes No Have you had any serious illness not listed above?_____

Are you Allergic to any of the following? **Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Bananas**

Other: _____

Are you taking or have you ever taken bisphosphonates? (Fosamax, Boniva, Actonel for osteoporosis, chemotherapy, etc) Yes No

Do you use tobacco? Yes No Do you use controlled substances? Yes No

Please list all medications you are taking: _____

_____

_____

Women Only:

Are you Pregnant/Trying to get Pregnant? Yes or No

Nursing? Yes or No

Taking Oral Contraceptives? Yes or No

Patient (Parent/Guardian): _____ Date: _____

Doctor: _____ Date: _____

Gilbert Smiles
Family & Cosmetic Dental Care

Consent Form and Financial Policy

Mission Statement:

Our goal is to build a long term relationship between our staff and our patients so that we can provide quality, consumer friendly, dental services the whole family can value and afford in a happy and healthy environment.

Scheduled Appointments:

I agree to give a minimum of **24 hr notice** to reschedule or cancel my exclusively reserved appointment time. My dental appointment represents a shared responsibility for both dentist and patient. In order to have quality dental care at affordable costs, these appointments must be kept. By initialing here _____ I understand and agree that **if proper notice is not given**, I will be charged a fee up to the amount of the scheduled procedure with a minimum fee of **$75.00**.

Texting:

By initialing here _____ I give my permission for Gilbert Smiles to use my mobile phone number to text appointment notifications and confirmation of appointments.

HIPAA Agreement:

A notice/copy of Gilbert Smiles HIPAA Privacy Practices has been made available to me explaining how Gilbert Smiles protects my confidential health information and what my rights are a patient. I give permission to Gilbert Smiles to contact me in writing, by E-mail or by telephone at home, work, or cellular phone to discuss any matters related to my account, appointments or any other matter relating to my treatment and care.

Financial Policy:

We are committed to providing you with the best possible care. In order to achieve this goal we need your assistance and your understanding of our payment policy. Payment for services is due on or before the day services are performed unless other arrangements have been made and approved in advance. We accept Cash, Check, Care credit, American Express, Master card, Visa and Discover. Financial arrangements will only be made with a credit card on file and on case by case bases. Funds will be drafted each month on the agreed date. In addition, I understand and agree to pay any unpaid balance within thirty days of date of invoice. I will be charged a late fee of $25.00 per month for any unpaid balance on my account. I will be responsible for any collection, attorney and/or court fees associated with my account.
This office is not a party in any divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for a minor's bill always rests with the accompanying adult. A parent or adult is required to remain in the office at all times while treatment is being rendered for a minor.

If Insurance Is Involved:

We will file claims on your behalf in most cases. Please understand that this is a medical facility and Dr. Swain cares about your health. It is Dr. Swain's responsibility to advise you of the status of your dental health and advise you of treatment needed based on your specific needs **NOT** based on your insurance coverage. It is your responsibility to provide us with your correct insurance information, including the insurance company name, address, phone number, group name and number and any other pertinent information, as well as cooperate with your insurance company to provide information to them if requested. We are unable to bill your insurance or provide you with an estimate if the information we have is not up to date.
If you have secondary Ins we will bill it for you however we are not able to give estimates for secondary Ins.

Please Be Advised:

We bill your insurance as a courtesy to you. However we do not take responsibility for your insurance plan, their fees, allowances, limitations and specifications. There are hundreds of insurance plans and it is impossible for us to know them all. Therefore it is the patient's responsibility to know and understand their individual plan. If you have specific questions about your plan you should contact your insurance directly.

WE WILL DO OUR BEST TO ESTIMATE WHAT INSURANCE WILL PAY AND WHAT THE PATIENT PORTION WILL BE FOR YOUR TREATMENT. THE ESTIMATED PATIENT PORTION WILL BE DUE AT THE TIME OF TREATMENT. ANY AMOUNT NOT PAID BY YOUR INSURANCE, REGARDLESS OF THE REASON, IS YOUR RESPONSIBILITY.

WE DO REQUIRE A CREDIT CARD TO BE ON FILE FOR ANY BALANCE NOT PAID BY YOUR INSURANCE COMPANY.

Circle preferred method of payment: VISA/MC/AMEX/DISCOVER/CARECREDIT

CARD#_____ EXP DATE _____ SECURITY CODE_____

CARD HOLDER SIGNATURE_____

I authorize the aforementioned form of payment for the following family members:

_____

Signature: _____ Date: _____

Terms & Conditions:

I, the undersigned, agree to all financial policies as listed above.
All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for by one of the above mentioned methods of payment the day services are performed.
I understand that all dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.
I understand if any balance becomes delinquent over thirty (30) days, it is agreed that Gilbert Smiles will have the authority to debit my charge account listed above or any payment form on file including CareCredit. We will impose a late payment charge of 1.5% per month (or maximum allowed by law). It is further agreed that I will be responsible for the attorney's fee and any other related costs for collection in the event that this account requires collections.

Assignment of Benefits:

I hereby authorize my insurance company to pay directly to my dentist, benefits accruing to me under my policy. I hereby authorize Gilbert Smiles staff to make insurance inquires on my behalf to insure proper handling and payment of all claims.

By signing below I also acknowledge being provided with a copy of "Dental Insurance Basics" (pages 1-3) that is designed to better explain how my dental insurance works and answer any questions I may have.
I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

Patient Name: _____

Patient/Parent Signature: _____ Date: _____

Oral Screening Consent Form

Complete each time the examination is performed and place in the patients chart.

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both incidence and mortality rate of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors**. Oral cancer risk patient profile is as follows:

Oral cancer risk by patient profile is listed below:

Increased Risk: Patients age 18-39 and sexually active patients (HPV 16/18)

High Risk: Patients age 40 and older; tobacco users younger than age 40

Highest Risk: Patients age 40 and older and lifestyle risk factors (tobacco use); patients with a history of oral cancer

We have incorporated ViziLite Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however this exam may not be covered by your insurance. The fee for this enhanced exam is $65.00.

YES. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financially responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

NO. I would not prefer to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____Date: _____