Patient Information

Dr. Alex Smolyar DMD
MULTISPECIALTY DENTAL PRACTICE

Date: _____

Patient

Prefix: _____ First Name: _____

Middle Name: _____ Last Name: _____

Suffix: _____ Name you preferred to be called: _____

Street: _____ ZIP: _____

City: _____ State: _____ Country: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unspecified

Emergency Contact: _____ Emergency Phone # _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____

Street: _____ ZIP: _____ City: _____ State: _____ Country: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unspecified

Signature: _____ Date: _____

Please provide us with a current e-mail and phone number. It will only be used to confirm future appointments.

Email: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Parent/guardian cell number: _____

Signature: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Street: _____ ZIP: _____ City: _____ State: _____

Insurance Information

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(If you do not have insurance, skip this page.)

Primary Dental Insurance

Is 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 Number:_____

Group/Contract Number:_____

Date of Birth: _____Subscriber SSN:_____

Patient Relationship to Subscriber:

☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

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Secondary Dental Insurance

Is 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 Number:_____

Group/Contract Number:_____

Date of Birth: _____Subscriber SSN:_____

Patient Relationship to Subscriber:

☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Health History

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Reason for Visit: ☐ Broken Tooth ☐ Check-up ☐ Cosmetic ☐ Dentures ☐ Tooth Pain ☐ Other:_____

Height: _____ ft _____ in Weight: _____ Patient Date of Birth: _____

Are you under the care of a primary physician? ☐ Yes ☐ No

Primary Physician's Name:_____ Physician's Phone Number:_____

Date of Last Physical: ☐ I don't know the exact date ☐ Last 6 months ☐ 6 months-1 year ☐ 1-3 years ☐ Over 4 years ☐ Never ☐ Other:_____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?

☐ Yes ☐ No How Long? _____

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Are you allergic or have you had an adverse reaction to any of the following? ☐ None ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex ☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other

List any medications you are taking, including non-prescription drugs and herbals/vitamins: ☐ None

_____

_____

_____

Check any conditions that apply to you:

☐ None
☐ Alcoholism
☐ Allergies or Hives
☐ Anemia
☐ Arthritis
☐ Artificial Joint/Pins
Type: _____
Age: _____
☐ Aspirin Therapy
☐ Asthma
☐ Blood Thinners
☐ Blood Transfusion
☐ Breathing Problems
☐ Cancer
Type: _____
☐ Chemotherapy
☐ Coumadin Therapy
☐ Dementia
☐ Diabetes
Type: _____
☐ Drug Addiction
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Hearing Impairment
☐ Heart Murmur
☐ Heart Surgery
Date: _____
☐ Heart Trouble
Type: _____
☐ Hepatitis
Type: _____
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease/COPD
☐ Lupus
☐ Mitral Valve Prolapse
☐ Mobility Impairment
☐ NON-DENTAL Implants
Type: _____
☐ Organ Transplants
Type: _____
☐ Pace Maker
☐ Psychiatric Care
☐ Radiation Therapy
☐ Radiosurgery
☐ Rheumatic Fever
☐ Seizures
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis (TB)
☐ Ulcers
☐ Visual Impairment
☐ Other Disease/Illness
Type: _____

Signature: _____ Date:_____

Dental History

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Date of Last Dental Visit: ☐ I don't know exact date ☐ Last 6 months ☐ 6 months-1 year ☐ 1-3 years ☐ Over 4 years ☐ Never ☐ Other:_____

Date of Last Dental X-ray: ☐ I don't know exact date ☐ Last 6 months ☐ 6 months-1 year ☐ 1-3 years ☐ Over 4 years ☐ Never ☐ Other:_____

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? ☐ Yes ☐ No

Age of dentures? ☐ Less than 6 months ☐ 6 months-3 years ☐ Greater than 4 years

Please check any conditions that apply to you below:

☐ Pain in Jaw (TMJ) ☐ Teeth Grinding/Clenching ☐ Use Tobacco Products ☐ Mouth Sores

☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date:_____

Are you nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand 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: _____

Financial Information

Payment Options

We strive to provide you with affordable, high-quality treatment that fits your budget! Your treatment plan will include a breakdown of all applicable fees, and we will inform you of all costs before treatment is administered. We offer a variety of payment options to meet your needs. Our office accepts payments by cash, checks, and Visa, MasterCard, American Express and Discover credit cards.

Affordable Financing Options

Don't let finances stand in your way of achieving the beautiful, healthy smile you deserve! We are pleased to offer in-house payment plans and, in some cases, third-party financing through CareCredit, including an option of a $0 down payment and low monthly payments that make your treatment more affordable. These flexible payment options allow you to pay for your treatment over a period of time so you can focus on what matters most—keeping your smile healthy!

Dental Insurance Information and Agreement

As a service to our valued patients WE SUBMIT TO ALL INSURANCE COMPANY PLANS AND FILE ALL INSURANCE CLAIMS FOR YOU ELECTRONICALLY.

The responsibility of the insurance company is to you and it is important that you ensure you are reimbursed properly. Fees for services provided to insured patients are the usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company.

The percentage of the fee paid may therefore be different than the percentage stated by your insurance company or different than the percentage listed in your benefit booklet. Dr. Smolyar has developed fees based on services provided and does not participate with insurance carriers in determining appropriate fees. In deciding whom they should participate with the doctors have selected YOU. We will do our very best to be certain that you receive all of the benefits due to you from your insurance carrier. If you have any questions please ask the office manager.

I wish to have you file my claims electronically. I have read the above completely and agree to the arrangements stated.

Signature: _____ Date:_____

I understand that the responsibility for payments for all services rendered in this office for myself and my dependents is mine, due at the time services are rendered, unless financial written arrangements have been made by the office manager and me.

Signature: _____ Date:_____

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 Policy that allows us to schedule appointments for all patients. When an 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 is as follows:

We require that you give our office **48 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that 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** 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 you are more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$75.00** cancellation fee will be applied.

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 your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I 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:_____

General Consents

1. The information presented on all pages is true to the best of my knowledge. The signed documents authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials needed by the doctor to make a thorough diagnosis of my dental health condition.

   I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

2. My condition, the nature of the procedure, and the benefits is reasonably expected compared with alternative approaches. Just as there may be benefits to the procedure proposed, I understand that all procedures involve risks to some degree. These general risks may occur in connection with the procedure(s) proposed for me: infection, bleeding, numbness, recurrence, or need for further treatment such as root canal therapy, or extraction.

   I am aware that other unexpected risks or complication may occur and that no guarantees or promises have been made to me concerning the results of any procedure or treatment. It has also been explained that during the course of the proposed procedures, unforeseen conditions may be revealed requiring the performance of additional procedures. I have read this form and have discussed it with my dentist, and I understand it. I request the performance of the procedure(s) described.

Name: _____

Patient Signature: _____ Date: _____

Patient Signatures

Release of Information to Insurers and Assignment of Benefits

(must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. Dental benefits will be payable to me by the insurance company.

Signature: _____ Date:_____

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

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient:_____

Relationship to the Patient:_____

I give authorization to disclose the following information:

☐ All treatment information ☐ Information specifically related to these treatment dates

Starting Date:_____ End Date:_____

Consent to Obtain Patient Medication History (Optional)

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/HIV and medicines used to treat mental health issues.

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 ("HIPPA").

Signature: _____ Date:_____

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