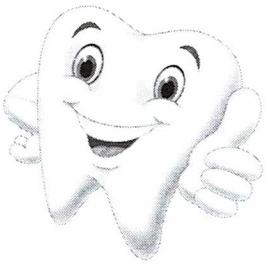
Smiles by Design - Oceanside



Today's Date: _____ **Reason for today's visit:** _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Preferred Name: _____ **D.O.B:** _____ **S.S. #:** _____

Sex: ☐ Female ☐ Male **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Address: _____

Email Address: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Whom may we thank for referring you? _____

Emergency's Contact Information

First and Last Name: _____ **Relationship:** _____

Emergency Phone #: _____

Responsible Party

(If someone other than you)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

D.O.B: _____ **S.S. #:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Primary Dental Insurance

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's D.O.B: _____

Insured S.S # OR Insurance's ID #: _____

Insured's Employer: _____

Insurance Company: _____

Insurance's Phone #: _____

Group # (Plan, Local or Policy #): _____

Secondary Dental Insurance

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's D.O.B: _____

Insured S.S # OR Insurance's ID #: _____

Insured's Employer: _____

Insurance Company: _____

Insurance's Phone #: _____

Group # (Plan, Local or Policy #): _____

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

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

If yes, please explain: _____

Previous Dentist Name & Phone Number: _____

Last Check up and Full Mouth X-rays _____ **Last Dental Cleaning:** _____

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3377 Long Beach Road
Oceanside, NY 11572
516-766-0732

- I HEREBY CONSENT TO ALL DOCTORS/HYGIENESTS TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS AND ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE.
- I AUTHORIZE DOCTOR TO PERFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON BY ME AND TO EMPLOY SUCH ASSISTANCE AS REQUIRED PROVIDING PROPER CARE.
- PLEASE UNDERSTAND THAT OUR RECOMMENDATIONS FOLLOW STANDARDS OF CARE, ***NOT*** BASED ON INSURANCE COVERAGE.
- PLEASE BE ADVISED THAT LASER/COSMETIC PROCEDURES ARE ***NOT*** COVERED BY INSURANCE. IT IS YOUR RESPONSIBILITY TO VERIFY ANY FEES PRIOR TO BEGINNING ANY PROCEDURES.
- I AGREE TO THE USE OF ANESTHETICS, SEDATIVES & OTHER MEDICATIONS AS NECESSARY. I UNDERSTAND THAT THE MENTIONED AGENTS EMBODIES CERTAIN RISKS AND I CAN ASK FOR A COMPLETE RECITAL OF ANY POSSIBLE COMPLICATIONS.
- THERE WILL BE A **$30.00** CHARGE FOR ANY APPOINTMENTS BROKEN OR CANCELED WITHOUT 24 HOUR NOTICE.
- ALL PAYMENTS ARE FINAL. BOUNCED CHECKS WILL INCUR A $40 FEE. If your account is sent to collections, there will be an additional collection fee

Insurance Authorization Form

Insured Name: _____

Relationship to insured: ☐Self ☐Spouse ☐Parent/Legal Guardian ☐Other _____

To Whom It May Concern:

I request that payment under the dental insurance program be made either to me or to the provider named above on any bills or services furnished to me during the effective date of the authorization.

I authorize the use of the words "***Signature on File***" in place of my signature on claim forms to authorize release of any information relating to this claim for the purpose of making payment.

I have read and understand the following New York State mandated Insurance Claim Fraud Notice:

Any person who knowingly and with intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is crime and subjects such person to civil and criminal penalties.

Optional assignment of benefit authorization: I authorize payment to be made directly to the provider named on above and on the claim form which would be otherwise payable to me.

Print Name: _____

Signature: _____ Date: _____

Medical History Information

Pharmacy's Name: _____ **Town:** _____ **Phone #:** _____

What medications are you currently taking? *(Please include all vitamins, over-the-counter or herbal supplements drugs)*

_____

_____

Are you allergic to any of the following?

☐ Latex ☐ Penicillin ☐ Codeine ☐ Clindamycin ☐ Aspirin ☐ Metal ☐ Local Anesthetics ☐ Other – please explain:

_____

Pregnant/Nursing? ☐ Yes ☐ No **If yes, how many weeks?** _____ *OR* **Taking Oral Contraceptives?** ☐ Yes ☐ No

Do you need to pre-medicate before any procedure? ☐ Yes ☐ No

Check *if you have or have had any of the following:*

- € Abnormal Bleeding
- € Aids/HIV positive
- € Alcohol Abuse
- € Alzheimer's Disease
- € Anemia
- € Angina
- € Arthritis/Gout
- € **Artificial Heart Valve** Date: _____
- € Artificial Bones/Joints
- € Asthma
- € Blood Transfusion
- € Breathing Problem
- € Bruise Easily
- € Cancer/ Chemotherapy
- € Chest Pains
- € Cold Sores/Fever Blisters
- € Colitis
- € Congenital Heart Disorder
- € Convulsions
- € Diabetes
- € Drug Addiction
- € Easily Winded
- € Emphysema
- € Epilepsy or Seizures
- € Excessive Bleeding
- € Fainting Spells/Dizziness
- € Genital Herpes
- € Glaucoma
- € Hay Fever
- € Heart Attack/Failure
- € **Heart Murmur**
- € Heart Pace Maker
- € Heart Trouble/Disease
- € Hemophilia
- € Hepatitis A, B or C
- € Herpes
- € High Blood Pressure
- € Hives or Rash
- € Hospitalized for Any Reason (please explain below)
- € Hypoglycemia
- € Irregular Heartbeat
- € Kidney Problems
- € Leukemia
- € Liver Disease
- € Low Blood Pressure
- € Lung Disease
- € Lupus
- € **Mitral Valve Prolapse**
- € Osteoporosis / Paget's Disease
- € Parathyroid Disease
- € Psychiatric Care
- € Radiation Treatments
- € Recent Weight Loss
- € Renal Dialysis
- € Rheumatic Fever
- € Rheumatism
- € Scarlet Fever
- € Shingles
- € Sickle Cell Disease/ Traits
- € Sinus Trouble
- € Stomach/Intestinal Disease
- € Stroke
- € Thyroid Disease
- € Tonsillitis
- € Tuberculosis
- € Tumors or Growths
- € Ulcers
- € Venereal Disease
- € Yellow Jaundice

Please list any serious medical condition(s) that you have ever had: _____

_____

_____

Dental History

Do your gums bleed while brushing or flossing?	☐ Yes ☐ No
Are your teeth sensitive to hot or cold liquids/foods?	☐ Yes ☐ No
Are your teeth sensitive to sweet or sour liquids/foods?	☐ Yes ☐ No
Do you feel pain in any of your teeth?	☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes ☐ No
Do you snore or have been told you snore?	☐ Yes ☐ No
Does your partner say you stop breathing while sleeping?	☐ Yes ☐ No
Have you been diagnosed with obstructive sleep apnea?	☐ Yes ☐ No
Do you use a CPAP machine for apnea?	☐ Yes ☐ No
Do you experience significant daytime drowsiness?	☐ Yes ☐ No
Do you have frequent headaches or migraines?	☐ Yes ☐ No
Do you clench or grind your teeth?	☐ Yes ☐ No
Have you had any head, neck, or jaw injuries?	☐ Yes ☐ No

Have you experienced any of the following problems in your jaw?

Clinking and/or Popping	☐ Yes ☐ No
Pain (joint, ear, side of the face)	☐ Yes ☐ No
Difficulty in opening or closing	☐ Yes ☐ No
Difficulty in chewing	☐ Yes ☐ No
Chronic sinus or ear congestion	☐ Yes ☐ No
Do you participate in any contact sports?	☐ Yes ☐ No
If yes, do you wear a mouth guard?	☐ Yes ☐ No
If yes, is it a performance enhancing mouth guard?	☐ Yes ☐ No

Do you like your smile?	☐ Yes ☐ No
Is there anything you would like to change?	☐ Yes ☐ No

Have you ever had any cosmetic procedures to?

Volumize or add definition to your lips...	☐ Yes ☐ No
Increase or add definition to your cheekbones...	☐ Yes ☐ No
Minimize wrinkles on your face/forehead...	☐ Yes ☐ No
Decrease nasolabial/marionette lines...	☐ Yes ☐ No

Have you ever had any cosmetic procedure such as:
- ☐ Botox, Dysport, Xeomin
- ☐ Juvederm, Restylane, Sculptura
- ☐ Radiesse

Are you interested in such services? ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical/dental status. I understand and agree that I am responsible for payment for all treatment rendered on my behalf or my dependants at the time of service.

X _____ **Date:** _____

Signature of Patient, Parent or Guardian

Financial Policy for Smiles by Design – Oceanside

We want our patients to be fully informed of our financial policy. We are committed to providing you with the best possible care. If you have dental insurance, we are determined to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our financial policy.

We make every effort to schedule your appointment at your preferred times. To be considerate to the practitioners and other patients of the practice, a charge of $30 will be levied for broken appointments, or appointments cancelled without twenty four hours advance notice.

If you have dental insurance, you must bring a completed dental claim form or proof of insurance and we will assist you by submitting your insurance claims. (**Please understand that New York State Law stipulates that if you have two dental policies, both must be submitted; please inform our staff of all of your insurances**.) With this in mind, please understand that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. We cannot render services on the assumption the charges will be paid for by an insurance company. All charges are your responsibility from the date that services are rendered.
3. Our fees are considered to fall with the acceptable range (U.C.R) for our area, and some insurance companies will determine their own U.C.R and maximum fees.
4. Not all services are covered in all contracts. Some insurance companies exclude certain services from their plan.
5. Please understand that our recommendations follow standards of care not what your insurance will or will not cover.
6. Please inform our staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.
7. Please understand that all laser or cosmetic procedures need to be paid in full at time of visit.
8. I understand that if there is a default of payment I will pay any fees incurred to collect such monies.

We must emphasize that as a dental care provider, our relationship is with you and not with your insurance company. While filing of insurance is a courtesy that we extend to our patients, all charges are your responsibility from the date of service.

I HAVE READ THE POLICIES DESCRIBED IN THIS FORM. I AGREE TO FOLLOW ALL TERMS OUTLINED. I UNDERSTAND AND ACCEPT MY FINANCIAL RESPONSIBILITY TO THE PRACTICE.

___ I agree to pay all estimated co-payments and deductibles at the time of visit. I understand it is my responsibility to bring cash, check or a credit card to every appointment.

** A credit card must be left on file and outstanding balances will be reconciled when insurance payments are received. **

Insurance Credit Card Authorization Form

Patient's Name: _____

Credit Card Holder's Name (please print): _____ **Expiration date** _____

Credit Card Number: _____ **Security Code:** _____

Patient Phone Number for Authorization*: _____

(*ONLY – if different from the number provided on the first page*)

I understand the insurance quotes that are given are only an estimate. Actual charges and covered benefits are only determined once the Explanation of Benefits from the insurance company is received. As a result, my account may have a balance which I am responsible for settling.

I authorize Oceanside Family Dental to charge the above card for any outstanding balances due to insurance coverage differences up to:

(PLEASE CHECK ONE)

☐ $50 ☐ $100 ☐ $150 ☐ Other:

If the balance exceeds the amount checked above, please contact me first via ☐ Phone OR ☐ E-mail/text before processing payment. Once payment is processed – PLEASE ☐ E-mail/text ☐ Mail ☐ Do Not Send Me a Copy

X _____ **Date:** _____

Signature

Smiles by Design – Oceanside

3377 Long Beach Road
Oceanside, NY 11572
(516) 766-0732

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

Our privacy practices are posted on the wall

I, _____ have reviewed a copy of this office's Notice of Privacy Practices.

The office may discuss my health information with my immediate family: ☐ Yes ☐ No

The office may discuss my health information with the following people only:

_____

Print Names

_____ _____ _____

Please Print Your Name **Signature** **Date**

***** FOR OFFICE USE ONLY *****

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign ☐ An emergency situation prevented us from obtaining acknowledgment
☐ Communications barriers prohibited obtaining the acknowledgment ☐ Other (Please Specify)

_____

_____

_____

ORAL CANCER SCREENING

The incidence of oral cancer continues to rise in this country annually. Traditionally, we have done oral cancer screenings with the naked eye, but today new technology exists to diagnose oral cancer at its earliest inception. Alarmingly, **25% of oral cancer victims** have no predisposing risk factors. The newest piece of technology to help us diagnose oral cancer is called **Vizilite**. The **Vizilite** uses a special, painless rinse to differentiate between potentially cancerous tissue and normal tissue. The exam can be done in minutes by our hygienists, and confirmed by the doctors if something seems suspicious. The exam allows us to find any abnormalities at their earliest onset even before it is visible by the naked eye, minimizing further treatment if a result is positive.
We strongly recommend that anyone over the age of 35 undergo a routine Vizilite exam annually. If you are a **smoker or chew tobacco**, we recommend this exam twice a year regardless of age.

This exam is not covered by dental insurance. The fee for this exam is $30.00. Please sign below in the appropriate spot to accept or decline treatment. Once again, we feel this breakthrough technology is important and in the long run saves lives.

YES ☐ **NO** ☐
I AUTHORIZE THE DOCTORS AND OR THE HYGIENEST TO PERFORM THE VIZILITE ORAL CANCER EXAMINATION TODAY.

Print Name _____

Signature _____ Date_____