THE CENTRE FOR CONTEMPORARY DENTAL CONCEPTS

Dr. Trent W. Smallwood

GETTING TO KNOW YOU…

Name:_____

Telephone : (_____) _____-_____ Date: _____ Age: _____

Welcome to Contemporary Dental Concepts. We are glad you have chosen to be our patient!

Let's get aquatinted…

Hobbies & Interests: _____

Family? Kids? (ages): _____

Business/Occupation: _____

REASON FOR TODAY'S VISIT

Today's dentistry allows us to enhance your smile quickly and easily. How would you like your smile to look? (circle what applies)

- ☐ Straighter
- ☐ Whiter
- ☐ Shorter
- ☐ Longer
- ☐ Wider
- ☐ More Even
- ☐ Close Spaces
- ☐ Replace Missing or Cracked Teeth
- ☐ Replace Partials/Dentures
- ☐ Fresher Breath
- ☐ Replace old crowns that don't match
- ☐ Replace black metal fillings with natural, tooth-colored fillings
- ☐ Have a personalized smile design make-over

Other Reason(s) for today's visit: _____

Are you preparing for a special occasion? Wedding? Reunion? Vacation?

When? _____

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Patient Registration

Patient Information

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

Address: _____ **Apt. Number:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **Cell:** (_____) _____-_____ **Text Messaging:** □ Opt In □ Opt Out (See Below**)

Email Address: _____ **Email:** □ Opt In □ Opt Out (See Below**)

Birth Date: _____ **Age:** _____ **Social Security #:** _____-_____-_____

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

Employment Status: □ Full Time □ Part Time □ Retired

Name of Employer: _____ **City, State:** _____ **Work phone:** (_____) _____-_____

Student Status: □ Full Time □ Part Time **Name of School:** _____ **City, State:** _____

Preferred Pharmacy: _____ **Phone:** (_____) _____-_____

Physicians Name: _____ **Phone:** (_____) _____-_____

Main Dental Concern: _____

Do you use a pre-medication prior to dental treatment (Antibiotic)? _____

How did you find our office? (Referral Source): _____

EMERGENCY CONTACT: _____ **Phone:** (_____) _____-_____

Responsible Party (if someone other than patient)

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

Address: _____ **Apt. Number:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____ **Cell:** (_____) _____-_____

Birth Date: _____ **Soc. Sec:** _____-_____-_____ **Relationship to Patient:** _____

□ Responsible party is also the Policy Holder for Patient □ Primary Insurance Holder □ Secondary Insurance Holder

Insurance Information (please provide insurance card)

Name of Policy Holder:_____ **Policy Holder Birth Date**:_____

Relationship of Patient: □ Self □ Spouse □ Child □ Other **Policy Holder SSN-or-ID #**:_____

Address (if different than Patient's):_____

City: _____ **State:** _____ **Zip:** _____

Name of Policy Holder's Employer: _____ **City, State:** _____

Name of Insurance Company: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

**We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain:_____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bipohosphonates?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you
Pregnant/Trying to get pregnant? Yes No **Taking Oral Contraceptives?** Yes No **Nursing?** Yes No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had any of the following?

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____
_____

Comments: _____
_____
_____

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 status.

Signature of Patient, Parent, or Guardian _____ Date _____

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AMERICAN DENTAL ASSOCIATION'S HIPPA PRIVACY FOR DENTIST

The Centre for Contemporary Dental Concepts

HEALTH INFORMATION PRIVACY POLICIES & PROCEDURES

These Health Information Privacy Policies and Procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a healthcare provider.

How We Collect Information About You: The Centre for Contemporary Dental Concepts ("CCDC") and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, sell, lend, or disseminate any information about applicants or clients who are treated by Genesis as it is considered confidential and is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to provide you with health or counseling services (including notification of health lectures, seminars, events, etc.) which may require communication between other health care providers, medical product or service providers, pharmacies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need; or to obtain or purchase any type of medical supplies, devices, or medications.

_____ _____

Patient/Guardian/POA Signature Date

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Written Patient Financial Agreement

You may not be aware, but dental insurance came about in the early 1960's and through the years Dental Insurance Companies have not increased their benefit to their patient even $1 and yet your monthly premiums have increased over 3000% in that time. We do our best with the insurance information given to us to verify your personal insurance coverage and to find out your benefits; however ***you need to be aware*** that the information they (your insurance) provide to us is ***very limited and is not a guarantee they will cover any procedures***. We will provide you with an ***estimate*** and your ***co-pay. Please remember that you, the Patient is ultimately responsible for the account and your insurance is only a third party of benefits. The balance and treatment is the patient's sole responsibility and NOT the responsibility of the insurance carrier or the dental office.*** You will receive a monthly statement to keep you aware of the status of your account. If your insurance has not paid The Centre for Contemporary Dental Concepts within 30 days of treatment, the balance will become the responsibility of the patient.

For Patient's with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment but the balance is ultimately the patient's responsibility.

_____ (Initial) The Centre for Contemporary Dental Concepts requires payment prior to beginning of your treatment. If you choose to discontinue care after treatment has commenced, a prorated amount of fees will be eligible for refund minus office expenses that have occurred. Down payment is required to secure your initial treatment appointment. This deposit is non-refundable if cancelled more than 24 hours after initial payment.

A fee of $50.00 is charged for patients who miss or cancel more than two times in a calendar year without 24 hour notice. We strive to respect the time committed by out patients and hope that you will respect the time we have allotted for you as well.

Insurance Are Only Estimates

Any and all estimates you have received from our office are just that…An Estimate! As a courtesy to our patients, we do phone your dental carrier for a breakdown of benefits and that information is reflected on your estimate and employees of this dental office are not responsible for that estimate. Unfortunately, your dental carrier will NOT guarantee any information given to us; therefore, we cannot guarantee what percentage of your treatment they will cover. We do not base our Diagnosis on what your Insurance will cover. Diagnosis of treatment is based on your dental health and what the teeth, bone, and/or gums are in need of, in a conservative approach. The patient is ultimately responsible for all charges incurred with our office should your insurance carrier not pay for any reason.

Please note that your dental benefit is VERY DIFFERENT than medical insurance. Medical insurance will often cover medical expenses in the 10's if not 100's of thousands of dollars. Whereas dental benefits have a very low maximum usually ranging from $500-$2000 per year. They are also very strict on what their benefits will cover and will often try to maneuver and exclusion to your benefit to minimize their cost, yet maximize your premium.

30 Days after Treatment

If your insurance has not paid or has made a less payment on your behalf, you are responsible for your account, and the remaining balance is due and payable immediately by you, the patient. It is your account, and the remaining balance is due and payable immediately by you, the patient. It is typical for insurance carriers to delay in their payment to the provider. We strongly urge you to call your insurance company after 30 days to pay on behalf of your claim to avoid having to satisfy the balance of your account. It is typical for insurance carriers to delay in their payment to the provider. We strongly urge you to call your insurance company after the 2 week mark as well as at the 30 day mark to pay on behalf of your claim to avoid having to satisfy the balance of your account and avoid late fees as described below.

Financial Agreement

_____ Payment in full for all Charges is required at the time of visit. Delinquent accounts (30 days or older) are subject to reasonable service charge and/or modest interest rates (based on a 2% interest rate per month).

_____ Collection Proceedings: We want to avoid any possibility of collections for your account, but in the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts will be reversed and you will be responsible for payment of regular fees for procedures at the time of service.

_____

Patient Name

_____ _____

Signature of Patient Date

_____ _____

Office Representative Date