PureSmiles Dental

Caring for you and your SMILE.

Dr. Michelle Bolton Gilich, DMD

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New Patient Package

Please Complete all Information that applies to you- Thank you

Caring for you and your SMILE.

PATIENT INFORMATION

Name:______________________________ Social Security #:_______________ Date of Birth:_________Sex:_______

Address:______________________________ City:__________________ State:____________ Zip: _______________

Home Phone:_______________________Work Phone:____________________Cell Phone: _____________________

Email:____

Check appropriate Box: Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Other [ ]

Referred to our office by:____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party or Guardian:_________________________________ Social Security #:_______________

Address (If different than patient)____________________________ City, State, Zip: ______________________________

Occupation:__________________________________ Employer: ____

Employer Address:____ Phone:______________________

How would you like to pay for you portion of the provided services? Cash [ ] Check [ ] Credit Card [ ] Other [ ]

RESPONSIBLE PARTY'S SPOUSE

Name of Responsible Party's Spouse:___________________________________ Social Security #: _______________

Address (If different than patient)____________________________ City, State, Zip: ______________________________

Occupation:__________________________________ Employer: ____

Employer Address:____ Phone:______________________

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company:__________________________________ Insured Name:________________________________

Insured Date of Birth:__________________________ Relationship to Patient: Self [ ] Spouse [ ] Child [ ] Other [ ]

Subscriber #:___________________________ Group # :____________________ Employer :___________________

Insurance Co. Address:____ Phone : ____________________

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company:__________________________________ Insured Name:________________________________

Insured Date of Birth:__________________________ Relationship to Patient: Self [ ] Spouse [ ] Child [ ] Other [ ]

Subscriber #:___________________________ Group # :____________________ Employer :___________________

Insurance Co. Address:____ Phone : ____________________

PATIENT MEDICAL HISTORY

General Health : Excellent [ ] Good [ ] Fair [ ] Poor [ ]

Physician Name:____________________________ Office Phone#:__________________Date of last visit:__________

List any medications you are currently taking:____

ALLERGIES Are you allergic to any medications? Yes [ ] No [ ] if "Yes" please check or list

Penicillin [ ] Codeine [ ] Latex [ ] Local Anesthetics [ ] Sulfa Drugs [ ] Barbiturates [ ] Sedatives [ ] Iodine [ ]

Aspirin [ ] Any Metals [ ] Other____

Please mark the ones that apply to you and your Medical History.

[ ] Need antibiotic coverage prior to dental work?

[ ] Artificial joint replacement or implant?

[ ] Undergone radiation or IV chemotherapy?

[ ] Use or have used tobacco products?

[ ] Subject to prolonged bleeding?

[ ] Family history of diabetes?

[ ] Excessive thirst and/or urination?

[ ] Recent unusual weight loss?

[ ] Subject to fainting?

[ ] Recently hospitalized or pas major surgeries?

[ ] (Women) Currently pregnant? ___How far?____

[ ] (Women) Currently nursing? ____

Please circle Y or N individually for each question:

Y N High or Low Blood Pressure	Y N Heart Disease	Y N Osteoporosis
Y N Heart Attack	Y N Cardiac Pace Maker	Y N Chest Pains
Y N Rheumatic Fever	Y N Heart Murmur	Y N Long-Term Steroid Treatment
Y N Swollen Ankles	Y N Artificial Heart Valves	Y N Scarlet Fever
Y N Fainting/ Seizures	Y N Frequently Tired	Y N Glaucoma
Y N Epilepsy/ Convulsions	Y N Emphysema	Y N Liver Disease
Y N Leukemia	Y N Cancer (type:_________)	Y N Hemophilia
Y N Diabetes (type:____) (A1C ____)	Y N Arthritis / Rheumatism	Y N Respiratory Problems
Y N Kidney Disease	Y N Jaundice/ Hepatitis(type:____)	Y N Mitral Valve Prolapse
Y N AIDS / HIV Infection	Y N Sexually Transmitted Disease	Y N Eating Disorders
Y N Thyroid Problem	Y N Stomach Troubles/ Ulcers	Y N Neck or Back Problems

Do you have any other medical or health conditions which is not listed? Yes [ ] No [ ] if "**Yes**" please list:

____

Signature:___________________________________ **Date:**__________ **Staff:**_________

Emergency Contact

Name of Relative or Person **Not Living** with you ______________________ Relationship to you ____________

Phone: ____________ Address: ____

Dental History

Previous Dentist: _____________ Last Dental Visit?________ Reason for today's Visit?____________________

Have you ever had a serious problem associated with a previous dental treatment? Yes [ ] No [ ]

If "**Yes**" please explain: ____

How often do you brush? __________How often do you floss? ________ How often do you get cleanings?________

What dental aids do you use? Floss [ ] Toothpick [ ] Water Pick [ ] Electric Toothbrush [ ] Other [ ] __________

Please answer Yes [ ] No [ ].

Are you hesitant to come to the Dentist ?	Yes [ ] No [ ]	Do you snore or have trouble sleeping?	Yes [ ] No [ ]
Do your gums bleed during brushing or flossing?	Yes [ ] No [ ]	Would you like to have a whiter & brighter smile?	Yes [ ] No [ ]
Do you have a bad taste or odor in your mouth?	Yes [ ] No [ ]	Would you like to have straighter teeth?	Yes [ ] No [ ]
Does food frequently get caught between your teeth?	Yes [ ] No [ ]	Do you have missing teeth that you would like to replace?	Yes [ ] No [ ]
Do you have dental fillings that you don't like?	Yes [ ] No [ ]	Do you have loose dentures or partials?	Yes [ ] No [ ]
Do you believe in the benefits of fluoride/	Yes [ ] No [ ]	Are you wearing away your teeth?	Yes [ ] No [ ]

What do you not like about your smiles? ____

What can we do to make your smiles look better? ______________________________________

Consent for Treatment

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 the incorrect information can be dangerous to my health. I hereby authorize Pure Smiles Dental (L. Michelle B. Gilich, DMD, P.A.) to administer and preform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to : pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other specific risks.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be ultimately responsible for payment on service rendered during my ineligible insurance period and any balance not paid by my insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all cost of dental treatment.

Responsibility for Payment: In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court cost incurred in making collection sums due and unpaid for the work herein set forth.

Signature : ________________________________ **Date :** ______________

Children or Minors

Because (name of child) ____________________ is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

Signature : ________________________________ **Date :** ______________

Caring for you and your SMILE.

FINANCIAL POLICY

Thank you for choosing PureSmiles Dental to serve your dental care needs. We strive to provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

- On your initial visit, we expect you to supply our office with your insurance information and a photo ID card. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with the changes. PureSmiles Dental will not be responsible for claims submitted to an insurance company by which you are no longer covered by.
- Full payment is due at the time the dental services are rendered. Patients covered by insurance are required to pay deductible and copayments at the time of each visit.
- While we accept most insurance plans, and are happy to aid in the submission of your claims, it is your responsibility to read and understand your policy and be aware of services covered or not covered by your individual plan.
- As a courtesy, we will gladly bill your insurance when you provide us with the current information and necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you pay your portion of the bill at the time of services rendered. Even though you may have an insurance claim pending , you will receive a monthly statement for your outstanding balance on your account until it is paid in full. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim**. Insurance policies are a contract between you, your employer and insurance carrier.** Pleas be aware that some, perhaps all of the service rendered may not be covered under your individual insurance policy. **You are ultimately responsible for full payment of your account.**
- If no payment is received on an account after two monthly statements, our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that ***" This will be final notice for payment".*** If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.

DELINQUENT ACCOUNTS

It is our policy to charge finance fees at 1.5% per month for outstanding patient balances after the balance has been outstanding for 30 days. In addition, all payments returned due to NSF will be subject to a $39.00 NSF fee.
All delinquent accounts past 60 days will be turned over to a certified Credit Reporting Collection Agency.

ESTIMATES AND FEES

After x-rays and examination , you are entitled to and should ask for an estimate of fees to cover necessary treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstance, such as pulpal therapy or cracked teeth could alter an estimated fee.

MISSED OR CANCELLED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for the missed appointments at the rate of $35.00 per 30 minutes of missed appointment time. Please help us service you better by keeping your scheduled appointments.

NOTICE OF PRIVACY PRACTICES (HIPAA)

A copy of our office Notice of Privacy Practices (HIPPA) is available to you in our office. You have the right to read our Notice of Privacy Practices (HIPPA) before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations. Of the uses and disclosures we may take of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. Upon request we can provide you with a copy of our Privacy Practices.

Signature: ______________________________ **Date:** ______________

Authorization for Signature on File

Release of Information / Financial Responsibility / Authorization for Payment

I (name of patient) ____________________________ and/or (name of insured) ____________________________ hereby authorize **PureSmiles Dental (L. Michelle B. Gilich, DMD, P.A.)** to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with (name of employer) ______________________________ . I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I release of any information relating to the claim.

Signature of Patient (parent or guardian if minor):_________________________________

Signature of Insured : ____

Today's Date: _______________