perfect smile dentistry

Welcome

[7593 Boynton Beach Blvd, Ste. 200 • Boynton Beach, Florida 33437 • (561) 732-3203]

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date:_____

E-mail Address:_____

Name:_____
Last First Mi Mr Mrs Ms Dr

I prefer to be called:_____ ❑ Male ❑ Female

Birth date:____/____/____ Age:____ SS#:_____

Home Address:_____
Apt/Condo #

_____
City State Zip

❑Single ❑Married ❑Partnered ❑Divorced/Separated ❑Widowed

Hm #: (____)_____ Cell / Other #:_____

Wk #: (____)_____ Ext:____ DL #:_____

Employer:_____

Employer's Address:_____

_____
City State Zip

How long there?_____ Occupation:_____

Where & when are best times to reach you?_____

Whom may we Thank for referring you?_____

Other family members seen by us:_____

Previous / Present Dentist:_____
(Please Circle)

Person Responsible for Account:_____

Spouse Information

His / Her Name:_____

Employer:_____

Wk #: (____)_____ Ext:____ SS #:_____

Birth date:____/____/____ DL #:_____

Relative or Friend not living with you

His / Her Name:_____ Relation_____

Wk #: (____)_____ Hm #: (____)_____

Insurance

Primary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

_____
City State Zip

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #):

Insured's Name:_____ Relation:_____

Insured's Birth date: ___/___/___ Insured's ID #:_____

Insured's Employer:_____

Employer's Address:_____

_____
City State Zip

Secondary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

_____
City State Zip

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #):

Insured's Name:_____ Relation:_____

Insured's Birth date: ___/___/___ Insured's ID #:_____

Insured's Employer:_____

Employer's Address:_____

_____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Continued on Back

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physisian's Name: _____

Phone #: (____)_____ Date of last visit: _____

Your current physical health is: ❑Good ❑Fair ❑Poor

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

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

Have you ever take Phen-Fen?

Also known as Redux or Pondimin. ❑ Yes ❑ No

If so, when? _____

For Women: Are you using a prescribed ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems

Y N	Abnormal Bleeding/Hemophilia	Y N	Herpes/Fever Blisters
Y N	AIDS	Y N	High Blood Pressure
Y N	Alcohol/Drug Abuse	Y N	HIV
Y N	Anemia	Y N	Hospitalized for Any Reason
Y N	Arthritis	Y N	Kidney Problems
Y N	Artificial Bones/Joints/Valves	Y N	Liver Disease
Y N	Asthma	Y N	Low Blood Pressure
Y N	Blood Transfusion	Y N	Lupus
Y N	Cancer/Chemotherapy	Y N	Mitral Valve Prolapse
Y N	Colitis	Y N	Pacemaker
Y N	Congenital Heart Defect	Y N	Psychiatric Problems
Y N	Diabetes	Y N	Radiation Treatment
Y N	Difficulty Breathing	Y N	Rheumatic/Scarlet Fever
Y N	Emphysema	Y N	Seizures
Y N	Epilepsy	Y N	Shingles
Y N	Fainting Spells	Y N	Sickle Cell Disease/Traits
Y N	Frequent Headaches	Y N	Sinus Problems
Y N	Glaucoma	Y N	Stroke
Y N	Hay Fever	Y N	Thyroid Problems
Y N	Heart Attack/Surgery	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers
Y N	Hepatitis	Y N	Venereal Disease

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

_____

_____

Are you allergic to any of the following

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry/Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

Medical History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Your current dental health is: ❑Good ❑Fair ❑Poor

Have you ever had a serious / difficult problem associated with any previous dental work ❑ Yes ❑ No

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑Hard ❑Medium ❑Soft

Have you ever had gum treatment? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that i may need during diagnosis and treatment, with my informed consent.

_____

Signature Date

Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.

Initials: _____ Date: _____

Doctor'sComments: _____

_____

_____

_____

_____

_____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Medical History Update

Has there been any change in your health status since your last visit? Y N

If yes, please explain. _____

_____ Patient Signature Date

_____ Dentist Signature Date

Has there been any change in your health status since your last visit? Y N

If yes, please explain. _____

_____ Patient Signature Date

_____ Dentist Signature Date

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Boynton Beach, Fl 33437

Insurance Estimation Policy

Please be advised that as a courtesy our office provides you with an estimate taken from your insurance breakdown for any proposed treatment. Any estimate given to you for your patient portion is only an **estimate**. We are not your insurance company; therefore, we can only go by the breakdown that we are given when we verify your insurance. Your insurance may cover **more or less** of the estimated amount. Each insurance policy is different. It is the responsibility of the patient to know and understand their insurance policy. If after your insurance pays their portion and there is a balance, you are responsible for the remaining balance.

As a courtesy, our office will be more than happy to go over your insurance breakdown with you; however, we are not responsible for limitations, exclusions or misinformation we receive from your insurance company on your policy. A breakdown is not a guarantee of payment until your insurance company receives and reviews your claim.

You can request a pre-treatment estimate of benefits prior to receiving any services to avoid any misunderstandings. This service is done at no charge to you.

I have read and understand the insurance policy of the office.

Print Name of Patient/Guardian _____

Signature of Patient/Guardian_____

Date _____

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Suite 200
Boynton Beach, FL 33437

Commitment to Financial Agreement

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. For the convenience of our patients we offer the following methods of payment:

A. Payment in full by cash, check, credit card, or alternate financing is required for each appointment as services are rendered. Please be advised that ***if a check is returned for insufficient funds*** your account will be charged a **$25.00 bank fee and a $15.00 processing fee**. A social security number is required from all patients if not paying by cash or if we are filing an insurance claim for you. This information is kept confidential and used for collection purposes only.

B. We will file your insurance claim form and accept payments from your insurance company, provided the deductible and any estimated non-covered fees are paid at each visit.

C. We allow up to **60** days for your insurance company to pay your claim. This allows sufficient time for you insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 3 days. Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all fees for services rendered. We will gladly assist you in any way we can. In the event this account becomes delinquent and past due, owing more than **30** (thirty) days from the date of billing, ***I hereby agree to pay all costs of collection including but not limited to interest, court costs, service of process fees, reasonable attorney's fees and collection costs as may be necessary.***

D. We value our patient's time therefore we make every effort to see our patients at their appointment time. We appreciate the same courtesy from our patients therefore if you cannot make your appointment please call us at least **48** hours ahead so that we have the opportunity to schedule another patient. If you do not show up for your appointment without calling our office there will be a **$55.00 "Broken Appointment"** fee added to your account.

E. *Parent or guardian must accompany patients under the age of 18 years old.*

Please be aware that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered.

We appreciate the opportunity to serve you, our valued patient.

_____ _____

Patient or Responsible Party Print Date

_____

Patient or Responsible Party Sign 7/28/2022

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, _____, have received a copy of the office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

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

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

_____

_____

_____

This Form is educational only, does not constitute legal advice and covers only federal, not state law (August 14, 2002)

perfect smile dentistry

PHOTO/WEBSITE CONSENT

PHOTO CONSENT:

I _____, hereby consent to allow Perfect Smile Dentistry to capture a photo of myself for their records.

Patient Signature _____ Date _____

****

WEBSITE/SOCIAL MEDIA CONSENT:

I _____, hereby consent to allow Perfect Smile Dentistry to post pictures or videos of me on their website or social media pages.

Patient Signature _____ Date _____

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