	Marbach Smiles Phone:	

PATIENT REGISTRATION

Patient is : □ ***Responsible Party*** □ ***Policy Holder***

Patient Information:

First Name: _____ Last Name:_____ Middle Initial:____

Address: _____City, State, Zip:_____

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

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

Email address: _____ Sex: ○ Female ○ Male

Student Status: ○Full Time ○ Part Time

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Responsible Party (if someone other than the patient):

First Name: _____ Last Name:_____ Middle Initial:____

Address: _____ City, State, Zip:_____

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

Birth date: _____ Social Security #: _____ Driver Lic#: _____

Email address: _____ Sex: ○ Female ○ Male

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Primary Insurance Information:

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

Name of Insured: _____ Member ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Emp. Phone Number: _____ Ins. Phone Number: _____

Medicaid/CHIP Information:

Plan Name: _____ Member ID: _____

Physician Name: _____ Phone Number: _____

Medical & Dental History

Patient Name _____ D.O.B. _____

Emergency Contact (Name/Phone Number) _____

Medical History

1. Physician_____Address _____

2.When was your last physical examination? _____

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

If yes, for what reason(s)? _____

4. Are you presently taking any medications/drugs/pills/herbals/supplements?..... ☐ Yes ☐ No

If yes, please list:_____

5. (Women) Is there a chance you are pregnant? ..... ☐ Yes ☐ No

If yes, anticipated due date?_____

6. Do you take oral contraceptives? ..... ☐ Yes ☐ No

7. Are you allergic/sensitive to: ☐None ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex ☐Pine Nuts ☐Dyes ☐ Other_____

8. Do you smoke, chew or use E-cigarettes? ..... ☐ Yes ☐ No

If yes, please indicate which one(s), daily frequency and how long?_____

9. Do you have Diabetes? ..... ☐ Yes ☐ No

If Yes, please indicate ..... ☐ Type 1 ☐ Type 2 Last HbA1c date and level_____

10. Do you have, or have you ever had:

Heart trouble	☐Yes	☐No	Excessive or prolonged bleeding	☐Yes	☐No
Heart murmur	☐Yes	☐No	Thyroid problem	☐Yes	☐No
Heart surgery	☐Yes	☐No	Jaundice	☐Yes	☐No
Heart pacemaker	☐Yes	☐No	Hepatitis(Type)	☐Yes	☐No
Rheumatic fever	☐Yes	☐No	Cancer	☐Yes	☐No
Congenital heart defects	☐Yes	☐No	Chemotherapy/radiation	☐Yes	☐No
Artificial heart valve/stent/graft	☐Yes	☐No	Arthritis	☐Yes	☐No
Abnormal blood pressure	☐Yes	☐No	Artificial joint replacements	☐Yes	☐No
Stroke	☐Yes	☐No	Cortico-Steroid treatment	☐Yes	☐No
Ulcers / GERD	☐Yes	☐No	Osteoporosis/treatment w/Bisphosphonates	☐Yes	☐No
Kidney trouble/Dialysis	☐Yes	☐No	HIV positive/AIDS	☐Yes	☐No
Tuberculosis or lung disease	☐Yes	☐No	Oral herpetic lesions	☐Yes	☐No
Asthma	☐Yes	☐No	Sexually Transmitted disease	☐Yes	☐No
Sinus trouble	☐Yes	☐No	Psychiatric care	☐Yes	☐No
Epilepsy / seizures	☐Yes	☐No	Glaucoma	☐Yes	☐No
Fainting spells	☐Yes	☐No	Hearing impaired	☐Yes	☐No
Anemia	☐Yes	☐No	Chemical dependency	☐Yes	☐No
Leukemia	☐Yes	☐No	Do you take pre-medication for anything	☐Yes	☐No
			If you pre-medicate for what		

11. Have you had any other serious illness, hospitalization or accident? ☐Yes ☐No

If yes, please explain:_____

Dental History

1. Former Dentist_____ Address _____

2. When did you last visit a dentist?_____ When was your last cleaning? _____

   X-rays taken? ..... ☐ Yes ☐ No

   If yes: ☐ Full Mouth Series ☐ Bitewings ☐ Panoramic

   What was done at your last visit? _____

   Why did you leave that dentist? _____

   Has any dental treatment been recommended to you that you have not had done? _____

3. Are you aware of any dental problems? ..... ☐ Yes ☐ No

   Explain: _____

4. Please rate the present condition of your mouth. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**

5. Have you ever been treated for gum disease? ..... ☐ Yes ☐ No

   If yes, what was done?_____

6. Do you have well water? ..... ☐ Yes ☐ No

7. Is your water fluoridated?..... ☐ Yes ☐ No

8. Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure

9. Please rate the appearance of your smile. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**

10. Would you like a whiter smile? ..... ☐ Yes ☐ No

11. Would you like straighter teeth? ..... ☐ Yes ☐ No

12. Have you had your teeth straightened/worn braces? ..... ☐ Yes ☐ No

13. Are you concerned with bad breath (malodor)? ..... ☐ Yes ☐ No

14. Are you concerned with snoring or sleep apnea? ..... ☐ Yes ☐ No

15. Are you concerned with grinding or clenching your teeth (bruxism)? ..... ☐ Yes ☐ No

16. Do you wear a bite guard? ..... ☐ Yes ☐ No

17. Are you aware of possible TMJ problems - does your jaw joint make noise, lock up or create pain? ..... ☐ Yes ☐ No

18. Are you interested in sleep/sedation dentistry?..... ☐ Yes ☐ No

19. Is there anything else that would be valuable for your dentist to know to best care for you? _____

_____

- **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.**
- **I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.**
- **I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.**

Patient Signature_____ Date _____

(Parent/Guardian)

Dentist Signature_____ Date _____

How did you hear about us?

___ Direct Mail/Flyer
___ Insurance Company
___ Newspaper
___ Facebook
___ Google / Search Engine
___ Community Event
___ School Event and/or Presentation
___ Billboard
___ Friend/ Family
___ Doctor
___ Drive By
___ Radio

Other :

Any other strategies you recommend helping spread awareness?
_____

Patient Name:_____ Date:_____

Financial Policy Consent Form

We welcome you and your family to Marbach Smiles. We look forward to providing you with top-notch quality dental care at affordable prices. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and treatment as much as possible.

You need to be aware that:

- We will always do our best to help you maximize your benefits.
- Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.
- Your treatment plan is individually tailored and is not based on your dental insurance benefits or lack of benefits.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

It is your responsibility to thoroughly understand the coverage and exceptions of your policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

- Our staff is trained to help yours with questions you may have relating to how your claim was filed, regarding any additional information your carrier may need to process your claim. Please, ask if you have any questions.
- As a courtesy to all our insured patients, we will file your dental insurance claim forms. In special circumstances, an insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately, and benefits are expected are to be paid within 30-45 days. The filling of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any other amounts your insurance company chooses not to pay for whatever reason.

Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail. I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction.

I agree to pay for all treatment in a timely fashion as described.

Refund Policy

All payments collected on the date of service may be refunded the same day. Refunds requested after the date of service will be processed within 15 days of refund submission form. Please note ALL PENDING INSURANCE CLAIMS must be paid by your insurance company before a refund may be made.

[For patients with dental insurance who would prefer their insurance Company send payment to the office]

I _____ hereby authorize my insurance benefits to be paid directly to **Marbach Smiles**. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether paid by said insurance, and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient/Legal Guardian Signature: _____ Date: _____

Staff Initial: _____

Appointment Policy

Monday through Friday appointments, 25% of your copayment for proposed treatment is collected at the time you schedule your next appointment.

Saturday appointments, 50% of your copayment for proposed treatment is collected at the time you schedule your appointment.

A cancellation fee of $15.00 will be issued for any failed appointments without a 24-hour notice.

MEDICAID/CHIP PATIENTS:

MCNA DENTAL & DENTAQUEST are notified through our automated system if you cancel or no show for your appointment. In order to keep your insurance active, you must follow your insurance company's policy.

Patient/Legal Guardian Signature:_____ Date:_____

If you may have any questions or concerns, please feel free to contact our business manager.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

Name:_____

DOB:

Patient Name (Please Print)

_____

Patient Signature Date:_____

OR

Signature of Personal Representative_____

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other:

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___A communication barrier prevented us from obtaining acknowledgement.

___The individual was unwilling to sign.

Other:_____

_____ _____

Staff Member Signature Date

Authorization for Use or Disclosure of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images, and or testimonial for marketing purposes by the practice listed below. I understand that disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations. This authorization expires ninety-nine (99) years from the date signed.

Purpose: The photographic/video images, and/or testimonial will be used for *Social Media interaction using Snapchat, Facebook, etc. and/or Advertising*.

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive.

No Treatment Conditions: I understand that the practice cannot condition treatment on or whether I sign this authorization.

If desired, copy provided:

- "*Yes, I would like a copy of this form.*"
  (Initial of team member; Copy provided by _____)

Practice Name: *Marbach Smiles*

Patient Name:_____ _____

Date: _____

Signature:_____

If Personal Representative

Name:_____ _____

Date: _____

Signature: _____ _____

Relationship to Patient: _____

If Patient is a Minor

Parent/Legal Guardian: _____ _____

Date:_____ _____

Signature: _____ _____

I DECLINE AUTHORIZATION: _____ ***(Initials)_____***

Informed Consent for Dental Treatment

Patient Name: _____ Date of Birth: _____

X-rays:

Proposed treatment: the taking of intraoral (inside the mouth) and extraoral (outside the mouth) radiographs.

Benefits of treatment; taking X-rays enables us to view dental cavities, abnormalities, development, and eruption of teeth. They are also necessary for proper diagnosis and evaluation purposes.

Alternative of treatment: none; limited visual examination.

Common Risks: minimal radiation exposure to soft and hard tissues of the head.

Consequences of not performing the treatment: misdiagnosis, possible loss of the tooth/teeth.

Cleaning (prophylaxis):

Proposed treatment: Involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal or soft plaques build-up and harder calculus deposits above and below the gum line.

Benefits of treatment: a healthy oral environment; also, reduction/elimination of bleeding, odor, and periodontal disease.

Alternatives for treatment: a healthy oral environment; also, reduction/elimination of bleeding, odor, and periodontal disease.

Alternatives to treatment: referrals for periodontal (gum) surgery according to the severity of the condition.

Common risks: bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint.

Benefits of treatment: to restore or improve the appearance and strength of teeth.

Alternatives of treatment: extraction for Orthodontic treatment (only in proper spacing, not damaged teeth).

Common risks: irritation to surrounding tissue, inflammation, irritation to nerve tissue, stiff or sore jaw joint, sensitivity to hot and cold, also possible root canal treatment.

Consequences of not performing the treatment: further destruction, nerve exposure, loss of tooth function, root canal treatment.

Tooth Extraction:

Proposed treatment: complete removal of a tooth from the mouth.

Benefits of treatment: to relieve symptoms and/or permit further planned treatment.

Alternatives for treatment: depending on individual treatment needs: root canal treatment, periodontal therapy, crown or filling, no treatment.

Common risks: as with any surgical procedure: discomfort, bleeding, swelling, possible damage to adjacent teeth and/or soft tissue, transient numbness of the jaw.

Consequences of not performing the treatment: increase in severity of pain, swelling, infection and possible hospitalization and rare instances of death.

I have read and understood the entire information on this consent form, which includes x-rays, cleaning, anesthetic, fillings, root canal treatment, crown and bridge, tooth extraction and implants. All my questions were answered to my full understanding and satisfaction. I have discussed treatment alternatives, risks, outcomes, and costs with my dentists and have had my questions answered before deciding.

Further, I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, I understand that I am responsible for payment. Dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in the treatment plan.

Patient/parent/ Guardian Printed Name

_____

Relationship to Patient

_____

Patient/ parent/ Guardian Signature

_____

Date

_____

Witness Printed Name

_____

Witness Signature

_____