PATIENT REGISTRATION

First Name:_____ Last Name:_____Middle Initial:_____

Preferred Name:_____

Patient is : □ Responsible Party □ Policy Holder

***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 #:_____Drivers Lic#:_____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

***Patient Information*:**

Address:_____City, State, Zip: _____

Home Phone:_____Work Phone: _____Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date:_____Social Security #:_____Drivers Lic#:_____

E-mail:_____ □ I would like to receive email correspondences

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

Preferred Pharmacy:_____ Referred By: _____

***Primary Insurance Information*:**

Name of Insured:_____Relationship to Insured: ○Self ○Spouse ○Child ○ Other

ID #: _____Insured Social Security #:_____Insured Birth Date:_____

Employer:_____ Insurance Company: _____

Address:_____ City, State, Zip:_____

***Secondary Insurance Information*:**

Name of Insured:_____Relationship to Insured: ○Self ○Spouse ○Child ○ Other

ID #: _____Insured Social Security #:_____Insured Birth Date:_____

Employer:_____ Insurance Company: _____

Address:_____ City, State, Zip:_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

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

ABSOLUTE SMILE, LLC

4469 Far Hills Ave/Kettering, OH 45429/ (937)293-9866

WRITTEN FINANCIAL POLICY

Thank you for choosing Absolute Smile, LLC Dental Spa. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, Visa, MasterCard, American Express or Discover Card

-Convenient Monthly Payment Plans from Care Credit. It allows you to pay over time with no annual fees or pre-payment penalties as long as Care Credit terms and conditions are followed.

Please Note:

Absolute smile, LLC requires patients pay their **estimated portion at time of service.** If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for any unpaid balance remaining on your account.

If an account remains unpaid for a period of 90 days, we have the right to assess a finance charge to the remaining balance of the account, until the account is paid in full. The amount of the finance charge is to be determined at the rate of 1 ½ % per month. In the event of default, the undersigned will pay reasonable collection costs including, but not limited to, attorney fees and court costs.

Absolute Smile, LLC uses the safest and highest quality restorative products available. It is possible that insurance companies may reimburse at a downgraded or lesser fee than the services provided. All remaining balances unpaid by your insurance company in any circumstance are ultimately your responsibility.

Appointment Policy

Absolute Smile, LLC reserves the right to assess any and all necessary fees for any appointments that are missed or cancelled without a 24-hour notice. After 3 missed or cancelled appointments, without a 24-hour notice, within a two year period, we reserve the right to dismiss you as an active patient.

Absolute Smile, LLC Charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need!

_____

PATIENT, PARENT or GUARDIAN SIGNATURE DATE

_____

PATIENT NAME (PLEASE PRINT)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Absolute Smile, LLC

4469 Far Hills Ave.

Kettering, OH 45429

937-293-9866

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand youR Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information, I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also, understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name:_____

Relationship to Patient:_____

Signature:_____

Date:_____