Patient Information Form

Name: ____ Date of Birth: _____________________

Social Security #: ___________________________ Drivers License: ___________________________

Home Address: ____

City: ______________________________ State: ______________ Zip Code: ______________

Home Phone: ______________________ Work Phone: ______________________ Ext: __________

Cell Phone: ______________________ E-mail Address: __________________________________

Do we have your permission to send you text messages? ☐Yes ☐No Email messages? ☐Yes ☐No

Spouse's Name: ____________________________ Phone: ______________________________

Parent's Name: _____________________________ Phone: ______________________________
(If minor child)

Physician: _________________________________ Phone: _______________________________

Employer: __________________________________ Phone: ________________________________

Nearest Relative not living with you: ______________________________ Phone: ____________________

Whom may we contact in the case of an emergency? Name: ________________________________

Phone: ___________________________ Relationship: ________________________________

Who is responsible for payment of services? ____

How did you hear about our office? ☐ Newspaper ☐ Yellow Pages ☐ Mailing

☐ Friend/Family __________________ ☐ Other (please specify) ______________________

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment for treatment. I consent, until revoked in writing, to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care: ____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed all answers. I certify this information is true and correct to the best of my knowledge. I will notify your office promptly of any changes in my status, insurance (if applicable) or any of the above information.

_______________________________________ ____________________________

Signature or Parent Signature (if minor) Date

ALL SMILES

Patient Insurance Form

Date ____________________________ Patient: ______________________________________

Primary Insurance:

Policy Holder: __________________________________ Policy Holder Phone: ____________________________

Policy Holder Date of Birth: ___________________ Social Security #: _______________________________

Policy Holder Employer: ____

Insurance Company: ______________________________ Insurance Co. Phone: ____________________________

Claim Group #: ____________________________ Member/Plan ID#:_______________________________

Secondary Insurance (if applicable):

Policy Holder:__________________________________ Policy Holder Phone: ____________________________

Policy Holder Date of Birth: ___________________ Social Security #: _______________________________

Policy Holder Employer: ____

Insurance Company: ____

Claim Group #: ____________________________ Member/Plan ID#:_______________________________

I hereby instruct and direct the above Insurance Company(ies) to pay for services rendered by check payable and mailed to **All Smiles, 133 Circle Way, Lake Jackson, TX 77566**. If my current policy prohibits direct payment to the doctor, I hereby instruct and direct you to make the check payable to me and mail it to:

____

Payment should be for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. **This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.** A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated on this ____________day of ____________________________, 20________.

____ ____

Signature of Primary Policy Holder | Signature of Claimant, if other than Policy Holder

____

Signature of Secondary Policy Holder

ALL SMILES

Health History Questionnaire

Date ___________________________

Your health history is very important to us. In order that we may provide you with the best possible dental services, please answer all questions as accurately as possible; incorrect information may compromise your treatment. This form is part of your dental treatment record and all information is confidential.

☐Mr. ☐Mrs. ☐Ms. ☐Dr.

Last Name ________________________________ First name________________________ Middle Initial________

Social Security #: ____________________________ Date of Birth _____________ Age ____

Reason for today's visit (please check all that apply)

☐Examination/Cleaning ☐Cosmetic ☐Pain/Swelling ☐Broken Tooth/Filling ☐TMJ

☐Other _______________ How long has this been a concern? __________________________________

Dental History

Do you feel you have (please check all that apply)

☐Painful teeth ☐Gum disease ☐Bad breath ☐Sensitive teeth ☐Jaw problems ☐Bleeding

Is there anything you would change about your smile? ☐Yes ☐No

If so, what? ____

Health History

Please list any **current major health problems**: ____

Have you had a physical exam in the last 2 years? ☐Yes ☐No

Physician's Name ____ Phone ________________________________

Past Medical History

1. **Have you ever had a serious illness, operation, or been hospitalized?** ☐Yes ☐No

If yes, please explain:____

2. Has there been a change in your health in the last 2 years? ☐Yes ☐No

If yes, please explain:____

3. **Have you ever had an allergic reaction to any of the following:** ☐Medication ☐Food ☐Latex

Name of Medication or Food: ____

Do you smoke or use tobacco? ☐Yes ☐No Do you drink alcohol? ☐Yes ☐No Use controlled substances? ☐Yes ☐No

Are you pregnant or think you may be pregnant? ☐Yes ☐No

Please list current medications:

____

____

133 Circle Way | Lake Jackson TX, 77566 | (979) 297-1128

Written Financial Policy

Thank you for choosing All Smiles. 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.

Unless other arrangements are made in advance, All Smiles requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For major services, payment of ½ of balance (not including insurance) is due on first visit and remainder to be paid at seating or final visit, unless other arrangements are made in advance. For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

A fee of $25 is charged for patients who miss or cancel more than 3 times in a calendar year without 24-hour notice.

All Smiles 1.5% interest on all past due accounts and $20 for returned checks.

Payment Options:

You can choose from:

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

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with check, credit card or cash prior to completion of care for treatment plans of $500 or more.

- Debit/Credit Card Withdrawal

We offer Automatic Debit/Credit Card withdrawal on a monthly basis for up to 12 months, with 20% down payment. If the card is declined for any reason, there will be a $20 fee.

- Layaway

We offer a layaway plan to allow our patients to pre-pay for their treatment. The plan includes a $20 non-refundable processing fee, 20% down and remainder payable over six months. Treatment would be performed after final payment.

- NO INTEREST[1] Payment Plans[2] from CareCredit

  - Allow you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

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

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

Please Initial Here: ____________

PLEASE READ AND SIGN IN BOX BELOW

MUTUAL AGREEMENT

Peter Norris, DDS and All Smiles (collectively labeled "*Dentist"*) agree to provide treatment to ___________________ ("*Patient*"). The Dentist takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, dentists are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dentist believes this is improper and may not be in the patients' best interest. Accordingly, Dentist agrees not to provide medical/dental information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Dentist has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Dentist - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication about Dentist, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Dentist for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Dentist's last date of service to Patient. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Dentist-Patient relationship.

Patient and Dentist acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Dentist agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS _____ DAY OF _______________, 200___.

____
Patient

Date

_______________________________________ _______________________________________
Peter Norris, DDS Parent/Guardian

PLEASE READ AND SIGN IN BOX BELOW

Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Further, I understand that I am entering into a contractual relationship with Dr. Norris for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Dr. Norris, I, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Dr. Norris.

Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness(es) who practice primarily in the same specialty as Dr. Norris. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and /or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this, Dr. Norris agrees to the same stipulations.

I acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Doctor's reputation and business. Both Dr. Norris and I agree in the event of a breach to allow specific performance and/or injunctive relief.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment
2. Infection in need of medication, follow-up procedures or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste
4. Damage to adjacent teeth, restorations or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
9. A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

______________________________	______________________________
Patient	Date
______________________________	______________________________
Print Patient Name	Parent/Legal Guardian
______________________________	
Witness	