LONDON BRIDGE SMILES **A Division of Atlantic Dental Care, P.L.C.**

Patient Information (please print)

Name_____ Social Sec. #_____ Date of Birth_____ Male/Female
First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____ E-mail_____

Employer_____ Occupation_____ Work Phone_____

Business Address_____ City_____ State_____ Zip_____

Marital Status_____ Spouse's Name_____ Spouse's Work Phone_____

How did you hear about our office?_____

Responsible Party (For MINORS)

Person responsible for this account_____ Relationship to Patient_____

Home Phone_____ Social Sec. #_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Employer_____ Occupation_____ Work Phone_____

Dental Insurance Information

Policy Holder/Subscriber_____ Relationship to Patient_____

Subscriber ID#_____ Subscriber's Social Sec. #_____ Date of Birth_____

Insurance Co. Name & Phone #_____

Employer/Group Name_____ Group #_____

Do you have any additional dental coverage? If so, please complete the following.

Policy Holder/Subscriber_____ Relationship to Patient_____

Subscriber ID#_____ Subscriber's Social Sec. #_____ Date of Birth_____

Insurance Co. Name & Phone #_____

Employer/Group Name_____ Group #_____

Consent For Services

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any possible complication.
4. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payment is 30 days late, I understand that the account will incur a 2% finance charge per month. If the account is referred to a collection agency, I understand that I will be responsible for the full account balance, collection costs, accrued interest and attorney's fees (33.3% of the total balance at time of placement).
5. **I understand that if I fail to make my scheduled appointments without giving two of our business days notice (Monday through Thursday) . London Bridge Smiles reserves the right to charge me for the lost time at a rate of $50.00 for each hour of an appointment.**

Patient Signature _____

LONDON BRIDGE SMILES **A DIVISION OF ATLANTIC DENTAL CARE, P.L.C.**

MEDICAL HISTORY

PATIENT NAME _____

Reason for today's visit_____ Date of last dental visit_____

Emergency Contact (not living with you)_____ Phone #_____

Physician's Name_____ Phone #_____

Are you currently taking any medications? Please List:

_____

Any Allergies? (Jewelry/Metals, Latex, Skin, Environmental, Medications)

_____

Do you have any of the following? (Check all that apply) Blood Pressure reading _____ Pulse _____

____AIDS/HIV Positive	____Diabetes- Type____	____Kidney Disease	____Scarlet Fever
____Anemia	____Eating Disorder	____Low Blood Pressure	____Seizures
____Arthritis	____Fainting	____Lung Disease	____Shortness of Breath
____Artificial Heart Valves	____Glaucoma- Type____	____Malignant Hyperthermia	____Sinus Trouble
____Asthma	____Hay Fever	____Migraines	____Stomach Problems
____Back/Neck Problems	____Heart Murmur/MVP	____Nervous Problems	____Swollen Ankles
____Blood Disease	____Hemophilia	____Pacemaker	____Thyroid Problem
____Blood Transfusion	____Hepatitis- Type____	____Prolonged Bleeding	____Tonsilitis
____Cancer	____Herpes	____Psychiatric Care	____Tuberculosis
____Canker Sores	____High Blood Pressure	____Radiation Treatment	____Venereal Disease
____Chemical Dependency	____TMJ/Jaw Pain	____Recent Weight Loss	____Joint Replacement

Do you smoke or uses any tobacco? Yes No

For office use: Any changes to Health History?_____

WOMEN

Are you pregnant? Yes No Planning on becoming pregnant in the next year? Yes No

If yes how many weeks? _____

Are you nursing? Yes No Are you taking Birth Control Pills? Yes No

Are you taking any medications for Osteoporosis or Osteopenia? Yes No Please List_____

Have you ever had eye surgery? YES NO

Type of surgery_____Date of surgery_____

Do you plan on having eye surgery in the next year? YES NO

Have you been admitted to a hospital or needed emergency care during the past two years? YES NO

If YES, please explain_____

To the best of my knowledge, all of the above information is true and correct. If ever there are any changes, I will inform London Bridge Smile at the next appointment without fail.

Patient's Signature_____ **Date**_____

LONDON BRIDGE SMILES

A DIVISION OF ATLANTIC DENTAL CARE, P.L.C.

PATIENTS NAME:_____

DENTAL QUESTIONNAIRE

1.	Are you concerned you will not keep your teeth the rest of your life?	Yes or No
2.	Are you nervous about having dental treatment?	Yes or No
3.	Rate your overall health (10= excellent—1= poor)	10 9 8 7 6 5 4 3 2 1
	Why? _____	
4.	Rate your overall dental health (10= excellent—1= poor)	10 9 8 7 6 5 4 3 2 1

PATIENTS IN PAIN OR HAVING A PROBLEM TODAY

1.	Are your teeth or gums sensitive to:	**HOT**	Yes or No
		COLD	Yes or No
		BITING PRESSURE	Yes or No
2.	Do you have pain that lingers for more than a few seconds or wakes you at night?		Yes or No
3.	Do your gums bleed when brushing or flossing?		Yes or No
4.	Do you have any swelling?		Yes or No
5.	Do you have an unpleasant taste or odor in your mouth?		Yes or No
6.	Do you have difficulty opening your mouth?		Yes or No
7.	Do you have a clicking or popping jaw?		Yes or No

CAN WE ANSWER ANY QUESTIONS YOU HAVE ABOUT:

- ☐ **WHITENING**
- ☐ **VENEERS**
- ☐ **COSMETIC SMILE ENHANCEMENT**
- ☐ **ORTHODONTICS**
- ☐ **INVISALIGN (CLEAR TRAY SYSTEM TO STRAIGHTEN TEETH)**
- ☐ **MAKING YOU TREATMENT MORE AFFORDABLE THROUGH CARE CREDIT**

London bridge smiles

A Division of Atlantic Dental Care, P.L.C.

FINANCIAL POLICY

Thank you for choosing London Bridge Smiles for your dental healthcare facility. We are committed to providing you with the best dental care resources available. In our ongoing process to make sure that all your dental needs are met, our billing department can discuss our fees and this policy with you should you need additional information.

We ask that all responsible parties read and sign our financial policy as well as complete and sign the patient forms prior to any services being rendered.

In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit.

We ask you pay a portion of your treatment in order to schedule and hold your treatment appointment. Payments for all services will be due in full at the time services are rendered. As a courtesy, we will be happy to bill your insurance carrier, although you are ultimately responsible for the entire bill.

As the responsible party please understand the following:

READ AND INITIAL:

_____1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with YOU, not your insurance company. We will supply only factual information to facilitate the claim process. We can do nothing about disputes over deductibles, co-payments, covered services, secondary insurances, "usual and customary charges", termination of coverage, or yearly maximums met. .

_____2. All charges are your responsibility whether your insurance company pays or does not. If your insurance company does not remit payment within sixty days the balance will be due in full. If your insurance company remits any payments to you directly billed by London Bridge Smiles, you recognize an obligation to remit payment over to us immediately. (Failure to do this is considered insurance fraud)

_____3. I understand that fees for services, which include unpaid balances, deductibles and co-payments are due prior

to scheduling future appointments.

_____4.I understand that returned checks and unpaid balances may be subject to collection placements, collection fees, accrued interest, and attorney's fees (33% at the time of placement).

_____5. I understand that if payments are 30 days a 2% finance charge per month or a $10.0 late fee which ever is higher.

_____6.I agree to be responsible for payment of all services on behalf of my dependents.

_____7. **I understand that if I fail to make a scheduled appointment for myself or dependents without giving two of our business days notice (Monday through Thursday). London Bridge Smile reserves the right to charge me for the lost time at a rate of $50.00 for each hour of an appointment. I will be responsible for paying for these charges.**

At London Bridge Smiles we encourage you to communicate with us if you have concerns or problems meeting your financial obligations, so that we may assist you in keeping your account in good standing. I understand the above information and will be responsible for the patient listed below.

PATIENT'S PRINTED NAME _____ DATE _____

Signature of Patient or Responsible Party_____ DATE _____

Name of Practice: London Bridge Smiles
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient(s) Name: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "Protected Health Information (PHI)" under a federal health privacy law, as described below:

Specific Description of the Information to be used or disclosed including the dates of service(s): Complete transfer of my medical record, all dates of service.

Person(s) or Class of Persons Authorized to make the requested use or disclosure: London Bridge Smiles a division of Atlantic Dental Care, PLC.

Person(s) or Class of Persons to whom the use or disclosure may be made: London Bridge Smiles a division of Atlantic Dental Care, PLC.

Purpose description of the requested use or disclosure: Complete transfer of all records for continuing treatment

This authorization expires on N/A; or the date the following event occurs: the transfer

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying the above named practice I authorized in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, and enrollment in a health plan or eligibility for benefits.

Name of Patient(s):_____

Signature of Patient/Parent or Guardian: _____ Date: _____

Patient's Date of Birth: _____

Would you like to give person(s) authorization to discuss and disclosure health and account information?

No: _____If yes please fill out information below.

Person(s) Authorization to Discuss and Disclosure Health and Account Information

Person(s) Authorized: _____

Relationship to Patient(s): _____

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Consent for Services

_____1. I authorize the doctor or authorized designated team to take necessary x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

_____2.Upon a diagnosis, I authorize the doctor and designated team members to perform all recommended treatment mutually agreed upon by me and the doctor.

_____3. I agree to the use of anesthetics and other necessary medication. I fully understand that using anesthetic agents embodies certain risks. I can ask for a complete recital of any possible complications.

_____4. I give permission to London Bridge Smiles to use my photographs for education and promotional purposes. I release my right for any compensation in connection with the use of these photographs.

Patient's name Printed _____ DATE _____

Signature of Patient (or Parent /Guardian) _____

HIPAA

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

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

_____

Please Print Patient's Name

_____

Signature of Patient/Parent/Guardian

_____

Today's 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:

- ☐ **The individual refused to sign.**
- ☐ **A communication barrier prohibited obtaining acknowledgement.**
- ☐ **An emergency situation did not allow time to obtain acknowledgement.**
- ☐ **Other:** _____