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

PLEASE READ AND INITIAL THE FOLLOWING

_____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 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 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/Guardian Signature _____ Today's Date _____

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) Please List:

_____

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 only: 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 diagnosed with Sleep Apnea? YES NO

Do you use a CPAP? 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 Smiles at the next appointment without fail.

Patient's Signature_____ Date_____

(Or Parent/Guardian)

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 YOUR TREATMENT MORE AFFORDABLE THROUGH CARE CREDIT**

London Bridge SMILES

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 a $25.00 fee for 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 past due, the account will incur a 2% finance charge per month or a $10.00 late fee, whichever is higher. If the account is referred to a collection agency, I understand that I will be responsible for the full account balance, collection costs, and attorney's fees (33.3% at the time of placement).

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

_____7. **I understand that if I fail to attend a scheduled appointment for myself or dependents 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. 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 _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA (CIRCLE ONE):

First Name Only Proper Surname Other: _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes stepparents, grandparents, and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM **MY APPOINTMENTS, TREATMENT, & BILLING INFORMATION** VIA (CHECK YOUR PREFERENCE)

- ○ Cell phone confirmation
- ○ Email confirmation
- ○ Text message to my cell phone
- ○ Work phone confirmation
- ○ Home phone confirmation
- ○ **Any of the above**

I AUTHORIZE INFORMATION **ABOUT MY HEALTH** TO BE CONVEYED VIA (CHECK YOUR PREFERENCE):

- ○ Cell phone confirmation
- ○ Email confirmation
- ○ Text message to my cell phone
- ○ Work phone confirmation
- ○ Home phone confirmation
- ○ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS, OR NEW HEALTH INFO** ON BEHALF OF THIS HEALTHCARE FACILITY VIA (CHECK YOUR PREFERENCE):

- ○ Cell phone call
- ○ Email
- ○ Text message to my cell phone
- ○ Work phone call
- ○ Home phone call
- ○ **Any of the above**
- ○ **None of the above** (opt out)

In signing this HIPAA Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please *print* name of Patient **Please *sign* Patient / Guardian of Patient**

OFFICE USE ONLY:

As privacy officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ○ It was emergency treatment
- ○ I could not communicate with patient
- ○ The patient refused to sign
- ○ The patient was unable to sign because: _____

Signature of privacy officer: