

DENTISTRY YOU CAN TRUST FROM A DENTIST WHO CARES.



972-463-1001

www.rowlettsmiles.com

7100 Rowlett Road, Rowlett, TX 75089

PATIENT INFORMATION

Date _____ DL# _____ SS# _____

Patient Name _____
Last Name

First Name _____ Middle Initial _____ "Preferred" _____

Address _____

City _____

State _____ Zip _____

Phone #s: Home _____ Work _____ Cell _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced

Patient Employer/School _____

Occupation/Hobby _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ Phone # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ Phone # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

Rowlett Smiles is a participating provider for Delta, Guardian, Assurant/DHA, Aetna, DeCare & Metlife dental PPO plans. If your insurance is with any other carrier, you may be "out of network" for your dental benefits. Any conflict or dispute over benefit coverage & fee schedules are between you & your insurance carrier. You will be responsible for any remaining balance. _____ initial

DENTAL INFORMATION

Reason for today's visit _____	Place a mark on "Yes" or "No" to indicate if you have had any of the following:	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Are you happy with your smile <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold/heat/sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Clicking or popping jaw/jaw pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like your teeth to be whiter <input type="checkbox"/> Yes <input type="checkbox"/> No
	Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	

HEALTH HISTORY

Physician's Name/Phone # _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema/Breathing or Lung Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur/MVP	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy/Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever taken osteoporosis medicines such as Fosamax? Yes No

Have you ever been told you need to take an antibiotic premed before any dental visit? Yes No

Do you have any other medical concerns? _____

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

Aspirin

Local Anesthetic

Barbiturates (Sleeping pills)

Penicillin

Codeine

Sulfa

Iodine

Other _____

Latex

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____ Phone # _____

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

Print Name

Signature

Date

I hereby release and give my consent for Rowlett Smiles to use my diagnostic photos and models to their discretion for marketing, educational or professional purposes and publications:

Signed _____ 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:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining the acknowledgement

___ Other (Please Specify)

INSURANCE & FINANCIAL RESPONSIBILITY AGREEMENT

At Rowlett Smiles, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

INITIAL:

- ____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- ____ I understand and agree it is **my responsibility** to know if my insurance has any deductibles, co-payments, age limits, exclusions, waiting periods, missing tooth clauses or any other type of benefit limitation for the services I receive and I agree to make full payment. Many times these exclusions are provided to employees only & are not made available to our staff when confirming benefits, they are your responsibility to know, we can only estimate based on what your insurance discloses to us.
- ____ We currently accept all private care insurance plans. We are currently a contracted provider for only: Metlife, Guardian, Delta Dental Premier, Cigna, Assurant, Humana & Aetna insurance plans. This means that we work with literally thousands of companies. It is your responsibility to know if Rowlett Smiles is a contracted in-network provider recognized by your insurance plan. Although we can maintain a computerized history of payments by a given company, they do change; therefore it is impossible to give you a **guaranteed quote** at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind that this is still not a guarantee of coverage. This does delay treatment but will give you the best estimate of what your out of pocket figures will be.
- ____ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Rowlett Smiles reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU and your insurance company**. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. Any delinquency on your account will result in a \$10/month late fee added to the account and finance charges at 18% annually will be applied. In the event that Rowlett Smiles incurs any expense in the collection of my account, expenses for collections agencies or court costs will be applied to my account.
- ____ **Rowlett Smiles** does require payment in full for your estimated portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with Care Credit, CitiHealth & Chase Financial who offer 3, 6, or 12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.
- ____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we do require at **least 24 hour** notice to avoid a **\$45/hour cancellation fee** (emergencies are an exception).

I agree with the above conditions.

Date: _____

Patient/Parent Signature: _____ Print Name: _____