NOVELSmiles

New Standards • New Beginnings

1 About You

Today's Date ________ / ________ / ________

Patient Name ________________________

Name you prefer to be called ________________________

Birth Date ________ / ________ / ________

Age ________ SS# ________________________

Address ________________________

City ________________ State ______ Zip ________

Home Phone # ________________________

Work # ________________ Cell ________________

Email ________________________

Referred by ________________________

Employer ________________________

Employer's Address ________________________

City ________________ State ______ Zip ________

Occupation ________________________

Married ___ Single ___ Divorced ___ Widowed ___ Minor ___

Spouse's Name ________________________

Children? ____________ If Yes, How Many ____________

2 Account Responsibility

Patient Name ________________________

Relation to Patient ________________________

Address ________________________

City ________________ State ______ Zip ________

SS# ________________________

Driver's License # ________________________ State ______

Work # ________________________

Payment Method: Cash ______ Check ______ CC ______

Credit Card ______ Visa ______ MC ______ AMEX ______ Disc.

______ (Initials) I hereby authorize assignment of my insurance rights and authorize benefits to be paid directly to the provider for any services rendered. I fully understand I am solely responsible for any charges or balances not paid by my insurance company (if offered at this office).

3 Insurance Info

Primary Dental Insurance

Co. Name ________________________

Address ________________________

City ________________ State ______ Zip ________

Insurance Phone # ________________________

Insured's SS# ________________________

Group/Policy # ________________________

Insured's Name ________________________

Relation ________________ Date of Birth ________

Insured's Employer ________________________

Secondary Dental Insurance and/or Medical Insurance

Co. Name ________________________

Address ________________________

City ________________ State ______ Zip ________

Insurance Phone # ________________________

Insured's SS# ________________________

Group/Policy # ________________________

Insured's Name ________________________

Relation ________________ Date of Birth ________

Insured's Employer ________________________

4 Emergency Contact

Emergency Contact #1 ________________________

Emergency Contact #2 ________________________

Relation to Patient ________________________

Address ________________________

City ________________ State ______ Zip ________

Contact #1 Work ________________ Cell ________________

Contact #2 Work ________________ Cell ________________

Primary Care Physician ________________________

Physician's Phone # ________________________

PLEASE CONTINUE ON BACK ➲ ➲ ➲

5 Dental Information

Reason for today's visit: Exam _______ Cleaning _______ Concsultation _______ Emergency _______

Other ____

Are you in pain? ______ No ______ Yes If yes, How Long ________________

Please indicate in the space provided with an "X" if you have any of the following problems:

_____ Discomfort, clicking or popping in the jaw
_____ Red, swollen or bleeding gums
_____ Sensitive tooth/teeth or gums
_____ Blisters/Soars in or around the mouth
_____ Lost/Broken filling
_____ Teeth grinding
_____ Ringing in ears
_____ Broken/Chipped tooth
_____ Stained teeth
_____ Locking jaw
_____ Bad breath
_____ Other ____

Do you require pre-medication? _____ Yes _____ No _____ Don't know

Previous Dentist Name ____________________ Phone # ____________________

Times a day you brush your teeth _________ Times a day you floss _________ Do you use a water pik? ______________

What type of tooth brush bristles do you use _______ Soft _______ Medium _______ Hard

Please rate your smile (1 being low) 1 2 3 4 5 6 7 8 9 10 Happy with overall look of your teeth ______ Yes ______ No

6 Medical History

Are you taking any of the following medications _____ Nerve pills _____ Pain killers _____ Muscle relaxers ________ Insulin _____ Blood thinners _______ Tranquilizers ______ Other : ______

Do you have, or haver ever had any of the following diseases or medical conditions?

Y N Heart Attack/Stroke
Y N Heart Surgery/Pacemaker
Y N Hear Murmur
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N Heart Disease
Y N Congenital Heart Defect
Y N Scarlet fever
Y N Bleeding Problems
Y N Kidney Problems
Y N Liver Problems
Y N Sinus Problems/Migraines
Y N Arthritis/Rheumatism
Y N Psychiatric Problems
Y N Venereal Disease
Y N Alcohol/Drug Abuse
Y N Frequent Neck Pain
Y N Chest Pain
Y N Cancer or Tumors
Y N Shingles
Y N Hepatitis
Y N HIV+/AIDS/ARC
Y N Leukemia or Lymphoma
Y N Artificial Bones/Joints
Y N Emphysema
Y N Tuberculosis (TB)
Y N Back or Spine Problems
Y N Glaucoma
Y N Chemotherapy
Y N Asthma or Bronchitis
Y N Difficulty Breathing
Y N Diabetes or Hypoglycemia
Y N Stomach Problems/Ulcers
Y N Anemia
Y N High/Low Blood Pressure
Y N Severe/Frequent Headaches
Y N Jaw Problems/TMJ/TMD
Y N Fainting/Seizures/Epilepsy

Other medical condition(s) you have - or have ever had: ______________________________

Are you allergic to any of the following ____ Latex ____ Pencillin/Amoxicillin ____ Aspirin ____ Dental Anesthetics

Others: ____

Do you use Tobacco ____ Yes ____ No How many packs _______ How Long ________

Do you wear _____ Glasses _____ Contact Lenses

Women Only: Are you taking birth control pills _____ Yes ____ No How many children have you had ______________

Please rate your overall general (1 being low) 1 2 3 4 5 6 7 8 9 10

We invite you to discuss with us any question regarding this form and our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for services rendered at the time of your visit unless other financial arrangements have been made with our business manager. If account is not paid within 90 days of the date of service, and no financial arrangements have been authorized, you will be responsible for collection agency fees, legal fees and any interest/late fees accrued. I authorize the staff to perform necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process any insurance claims. I understand the above information and warrant/guarantee this form, and the information contained within, is true and correct to the best of my knowledge. I further understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________________ Date _______/_______/_______

____ Adult Patient ____ Parent or Guardian ____ Spouse

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I. INFORMED DENTAL CONSENT Novel Smiles Dental Center, LLC

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning any invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is risk associated with dental procedures and all of your questions have been answered. Dental treatment and dental procedures are not to be taken for granted as routine or without the risk of complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body, there are many variables involved, some predictable and others not. Complications in dentistry are very low but they do exist. Even minor procedure like a simple 'filling' can lead to major complication that can't be foreseen. For example, a 'Novocain' or local anesthetic injection could lead to an allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating treatment should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments. The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I have read and understand Informed Dental Consent and consent to dental treatments.

Signature_______________ Date _______

II FINANCIAL POLICY

1. Patients WITH Insurance Coverage:

Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments of your account. We can request a pre-estimate of benefits from your insurance carries if you request to do so. Routine treatments are generally performed without submitting a request of pre-estimate of benefits. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to the treatment. In some cases, insurance carrier may pay for alternative benefits other than the treatment performed. In this case, you are responsible to pay for the difference. Even if you have dual coverage (which is possible when you and your spouse both have insurance) there may still be a portion that is your responsibility. All procedures involving lab work will require 50% down payment, then the remaining 50% balance will be due as treatment progresses. The balance must be paid before final insertion. If you are having extensive treatment over a period of time, we request payments during the course of treatment. Our financial coordinator will assist you in arranging a payment schedule.

Signature ________________. Date ________.

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Billing Policy

1. Checks returned unpaid from the bank are subject to $35.00 service fee.

2. Accounts delinquent more than 90 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to collection agency you will be responsible for collection and court costs along with attorney's fees.

We welcome you to our office and want to provide you with the best care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

Cancellation Policy

OFFICE POLICY CONCERNING APPOINTMENTS

When you make an appointment we reserve the time for you. We understand that extreme or unavoidable emergencies do arise which may require you to cancel your appointment. We reserve the right to charge for any appointment(s) broken without a 24 hours' notice.

NOTICE: The Charge will be **$75** for every appointment missed.

I HAVE READ AND UNDERSTAND NOVEL SMILES LLC'S; INFORMED DENTAL CONSENT, FINANCIAL POLICY, SCHEDULING POLICY AND BILLING POLICY.

Signature Date

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PATIENT HIPAA C ONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this

Information serves as:

- Basis for planning my care and treatment
- Means of communication among the many health professionals who contribute to my care
- Source of information for applying my diagnosis and surgical information to my bill
- Means by which a third-party payer can verify that services billed were actually provided
- Tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Signed this _______day of _____________ 20_______.

Print Patient Name ___________________________________

Signature ___________________________________

Relationship to Patient ______________________________