Welcome to our Practice

Thank you for choosing our office for your dental care.
We are dedicated to providing you and your family with the highest quality of care, using state of the art treatment in a comfortable and professional environment. Please familiarize yourself with the policies of this office. This form must be read and signed before treatment is rendered. **Please ask questions if you do not understand any of these policies.**

Appointments

In order to provide quality, effective care, we utilize an appointment schedule. Our office hours are Monday through Thursday 8 am to pm, and Friday 8 am to pm. (closed for lunch pm). We aim to give you all the time and attention your dental care requires while you are in our office. However, if you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment. We are available when emergencies arise, and will do our best to give prompt consideration as needed.

Children Appointments

However, we do require that you remain in the building with minor children (under 18 years of age) for the entire appointment. We provide children with the same care that our adult patients receive and prefer to care for them as individuals.

Cancellation Policy

As a courtesy, we will attempt to confirm your reservation for treatment prior to the appointed date. Smiles Up cannot guarantee a reminder call. To cancel your appointment, please notify our office at least twenty-four (24) hours in advance of your scheduled appointment time. Appointment changes can only be accepted during regular office hours. You may be charged a fee for not providing a twenty-four (24) hour notice of cancellation or failing to show up for the appointment. The fee will vary depending on the amount of time scheduled and will not be less than $50.00. Two (2) missed appointments may lead to an inability to schedule you for future appointments.

Patient Name (Please Print)	Patient |Parent or Guardian Signature	Date

Financial Agreement

I understand that my insurance policy is a contract between myself and the insurance company, and Smiles Up is not a party to that contract. I am responsible for unpaid balances and non-covered services, which may result in additional fees. I am responsible for informing the office of all changes to my information and insurance prior to my appointments. Insurance must be in force and verifiable at time of treatment, and if I do not have insurance, I agree to pay in full at the time of the appointment. Balances over 30 days may be subject to 2% late payment fee per month. I hereby assign all insurance benefits for services rendered, otherwise payable to me, directly to Smiles Up from Medicaid or my private insurance. I authorize Smiles Up to release medical information to my insurance company, its agents or any third party for use in determining my benefits. If my account enters a delinquent status, I agree to pay all costs of collections including attorney fees and court fees, if applicable. If my account enters court collection status, I accept that I will no longer be a patient of record. I understand that the fee for a returned check is $35. Smiles Up will maintain patient records for a minimum of seven (7) years following the latest date of service, barring any exceptions where required extended retention may be required.

Medicaid Insurance

If you have Medicaid insurance, you must have your card, picture ID, and your required $3.00 co-pay. If you do not have all of these requirements we will have to reschedule your appointment. Please note that Medicaid Insurance can only be filed at certain Riccobene Associates Family Dentistry Locations.

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____________________	____________________	________
Patient Name (Please Print)	Patient |Parent or Guardian Signature	Date

Patient Information

Please complete in ink (Required*)

*Full Name____*Date of Birth________________________________

*Email Address____

*Address____*City_______________*State____*Zip Code__________

*Telephone: Home_________________________*Work______________________ *Mobile______________________

*Social Security #_____________________________*Driver's License#______________________________________

Occupation__________________________________Employer____

Gender____________________Age______________Height___________________Weight_________________________

*Emergency contact name: ______________________________________*Phone:_____________________________

Preferred method of billing ☐ **By Mail** ☐ **Online Billing (using email address above)**

*GUARDIAN OR RESPONSIBLE PARTY

Full Name____Relationship________________________________

Address____ _______________________

Home Phone_________________________*Work________________________*Mobile_________________________

*INSURANCE POLICY

Name of Insured____

Date of Birth___________________ Social Security____

Employer________________________________ Insurance Company____

Address____

Policy#____________________________Group#______________________Phone#_____________________________

Do you have additional dental insurance? Yes No If yes, please notify our staff.

We are happy to assist you in understanding and filing your insurance for most dental procedures. Please remember your insurance is a contract between you, your employer, and your insurance company. Please understand that we cannot speak on their behalf. We will gladly act as an advocate but cannot be responsible for settling any disputed claims or coverage. We require payment of patient's estimated portion at the time of treatment. Our office policy states that you are solely responsible for your bill. If we do not receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

___________________________________ ____ ________________

Patient Name (Please Print) Patient |Parent or Guardian Signature Date

All information provided here is kept completely confidential, thus any attempt to conceal pre-existing conditions or other relevant information could result in serious patient – drug interactions or death. The following questions must be answered honestly so our office can provide you with the best possible care and service. If we determine that questions have not been answered honestly, you will be dismissed from our practice.

Please indicate your response by placing a checkmark in the appropriate column.	Yes	No
Have you ever been seriously ill?		
Have there been any changes in your general health recently?		
Is a medical doctor currently treating you?		

Please provide your medical Dr.'s name and phone number.

____

Please list all medication(s) (Prescription or Over-the-Counter) that you take:

____

____

Have you ever had a major operation or been hospitalized?		

If yes, please specify____

Have you had a physical exam within the last year?		
Have you ever had to take antibiotics before having dental work?		
Do you have artificial joints, heart valves, or an organ transplant?		
Do you have chest pains upon exertion?		
Have you ever had x-rays for a tumor, growth, or other condition?		
Are you allergic to, or have you had unusual reactions to any of the following? If Yes, circle all that apply: Penicillin - Aspirin - Iodine - Codeine - Latex - Erythromycin - Sulfa Drugs - Barbiturates Other__________________		
Have you ever been exposed to the AIDS Virus (HIV)?		
Are you currently using any recreational drugs such as marijuana or cocaine?		
Have you ever taken the drug Phen-Phen?		
Have you ever had a blood transfusion?		
Have you ever experienced an unusual reaction to dental anesthetic?		

If the doctor or staff member suffers a needle stick or puncture wound, you may be requested to submit to a blood test to determine the presence of any blood borne pathogens per NCAC Chapter 130 of the NC General Statutes

______________________	______________________	__________
Patient Name (Please Print)	Patient |Parent or Guardian Signature	Date

Have you ever had or have you been told that any of the following pertain to you:

Condition:	Yes	No	Condition	Yes	No
Mitral Valve Prolapse			Herpes – If yes, Type 1 or 2 (circle)		
Heart murmur			Epilepsy		
High Blood Pressure			Hives/Skin Rash		
Diabetes			Seizures		
Heart Attack – Date:			Anemia		
Cancer - If Yes, Type:____________			Kidney Disease		
HIV/AIDS			Jaundice		
Rheumatic Fever			Asthma		
Hepatitis If yes: A B C (circle)			Hay Fever		
Tuberculosis			STD – If yes, type:_______________		
Other (please list) ____________________________					

	Yes	No
Do you have shunts for dialysis or for any other condition?		
Do you bleed for a long time when you cut yourself?		
Do you have frequent or severe headaches?		
Do you have sinus trouble?		
Do you have painful or swollen joints?		
Do you have frequent cold sores or canker sores?		
Do you have complaints about your ears/hearing?		
Do you have frequent colds?		
Have you gained or lost weight in the last few months?		
Has your appetite changed recently?		
Please list any foods that you are allergic to:		
Are you currently or have you taken in the past Bisphosphonate medication (Fosamax, Actonel, Boniva, Aredia, Bonefos, Didronel, Zometa) to treat osteoporosis or as part of cancer treatment therapy? (Medications would include both oral and Intravenous).		

For Women only:

Women who take oral contraceptives (birth control pills) should take extra precautions when taking antibiotics because antibiotics can cause failure of birth control pills which can result in pregnancy

	Yes	No
Are you pregnant or suspect that you may be pregnant? If yes, How many weeks: _______		
Are you taking oral contraceptives (birth control pills)?		
If you use other types of birth control medications that are not pills (such as Depo shots), please list: ____		

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge.

________________________________ ____________________________________ ______________

Patient Name (Please Print) Patient |Parent or Guardian Signature Date

Dental Health Questionnaire

My dental health and treatment goals are: (Please circle all that apply to you)

Pain free	Replacing missing teeth	Sedation dentistry
Whiter teeth	Full dentures	Decrease Sensitivity
Straighter teeth	Cavity free	Hollywood Smile
Healthier gums	Better breath	Partials
Stop smoking	Less bleeding	Better chewing

Other:_________________

When was the last time you were seen by a Dentist? ___________________________________

When was the last time your teeth were cleaned? ______________________________________

Do you have well or county water? ____

What type of toothbrush do you use? (circle your choice) Hard Medium Soft or Electric

Which over the counter oral rinse(s) are you using? _____________________________________

	Yes	No
May we take dental x-rays on you if they are needed?		
Do you take fluoride supplements?		
Have you ever had periodontal (gum treatment)?		
Have you ever had orthodontic treatment (braces)?		
Do you floss regularly? (circle your closest frequency) Daily 2-4x/wk 1x/wk Periodically		
Do your gums bleed when you brush or floss?		
Have you ever been concerned about bad breath?		
Do you consistently get a bad taste in your mouth?		
Are you nervous?		
Have you ever been sedated for dental treatment?		
I consent to the diagnostic procedure and treatment by the dentist necessary for proper dental care.		

Please help us know how you found us by circling one of the following:

Insurance Provider	Radio	Groupon	Vendor Expo
Online Search	Facebook/Twitter	Angie's List	Other_______________
Personal Referral	Drive By/Walk-in	Coupon	

_______________________________ ___________________________________ ______________

Patient Name (Please Print) Patient |Parent or Guardian Signature Date

PRIMARY AND SECONDARY INSURANCE POLICY

provides the courtesy to our patients of filing both primary and secondary insurance.

However, both ADA policy and state COB laws provide that when an insurance company accepts premiums from an employer and the secondary carrier, it should coordinate benefits with the primary carrier and pay its appropriate amount as follows:

1. The coverage from those plans should be coordinated such that the patient receives the maximum allowable benefit from each plan;

2. The aggregate benefit should be more than that offered by any of the plans individually, but not such that the patient receives more that the total charges for the dental services received.

Therefore, if there is overpayment on your claim from your secondary insurance, the additional funds will be returned to your secondary insurance company, and will not be refunded to the patient. This is required by the National Association of Dental Plans (NADP), and American Dental Association (ADA).

Determining Primary and Secondary Insurance for the Patient.

The plan covering the patient, other than as a dependent, is the primary plan. When both plans cover the patient as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary. When a determination cannot be made in accordance with the above, the plan that has covered the patient for a longer time should be considered as primary. Smiles Up provides this information to help patients understand primary and secondary dental policy. Should you have additional questions we recommend for you to contact your dental insurance provider or review the American Dental Association website at www.ada.org.

By signing below, I understand that follows ADA and state guidelines for primary and secondary insurance policies.

Patient Name (Please Print)	Patient |Parent or Guardian Signature	Date

I ________________________________ (printed name) acknowledge I have been provided a reference copy of the HIPAA Notice of Privacy Policy and may request a copy of said policy.

Furthermore, I understand my personal health, insurance or other personal information collected by Smiles Up will only be used as described in the aforementioned Notice of Privacy policy.

My signature at the bottom of this page indicates I have received, read, and understand that Smiles Up has communicated, to me, my rights under HIPAA.

Patient Name (Please Print)	Patient |Parent or Guardian Signature	Date