Charming Smiles of Naples

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all you dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help!

Patient Information (CONFIDENTIAL)

Date_____

NAME_____ Birthdate_____ Home Phone_____

Address_____ City_____ State/Zip_____

Email (optional)_____ Cell Phone_____ Soc. Sec. #_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer_____ Work Phone_____

Business Address_____ City_____ State/Zip_____

Spouse or Parent/Guardian's Name_____ Work Phone_____

Spouse or Parent/Guardian's Employer_____ City_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency (living in same home)_____ Phone_____

Person to Contact in Case of Emergency (not living in same home)_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Email (optional)_____ Cell Phone_____

Driver's License #_____ Birthdate_____ SSN_____

Employer_____ Work Phone_____

Is this person currently a patient in our office? ☐ Yes ☐ No Are there other family members? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer:

☐ Cash ☐ Personal Check Credit Card: ☐ VISA ☐ MasterCard ☐ Care Credit

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN_____ DateEmployed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State/Zip_____

Insurance Company_____ Group #_____ Policy ID #_____

Insurance Co. Address_____ City_____ State/Zip_____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State/Zip_____

Insurance Company_____ Group #_____ Policy ID #_____

Insurance Co. Address_____ City_____ State/Zip_____

Charming Smiles
4060 Pine Ridge Rd
Naples FL 34119

Patient's Medical History

Patient's Name _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes	○ No	○ N/A	_____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	○ N/A	_____
Have you ever had a serious head or neck injury?	○ Yes	○ No	○ N/A	_____
Are you taking any medication, pills, or prescription drugs?	○ Yes	○ No	○ N/A	_____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	○ N/A	_____
Are you on a special diet?	○ Yes	○ No	○ N/A	_____
Do you use tobacco?	○ Yes	○ No	○ N/A	_____
Do you use controlled substances?	○ Yes	○ No	○ N/A	_____

Women: Are you ☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Local Anesthetics ☐ Other (Please specify) _____

Do you have, or have you ever had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problems	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

*Condition may require medication. N/A – Not answered by patient

Have you ever had any serious illness not listed above? Yes NO N/A If yes, please specify _____

Comments: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____

Signature of Patient, Parent or Guardian Date

DENTAL HISTORY

NAME: _____

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following:

- ☐ Dentures
- ☐ Partial denture
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

- ☐ Your last cleaning ____/____
- ☐ Your last oral cancer screening ____/____
- ☐ Your last complete X-rays ____/____

***Name of Previous Dentist*:**

_____

City: _____ State:_____

Phone Number: (___)_____

***General Anesthesia Questions:* (required)**

Height: _____ Weight: _____

Have you ever had any unusual reactions or complications to medications or anesthesia?

☐ Yes ☐ No ***Is yes, please explain below:***

_____

_____

_____

Are you interested in whiter teeth?

☐ Yes ☐ No ☐ I would like more information.

Do you smoke or use chewing tobacco?

☐ Yes How Much _____

How Long _____

☐ No

If you could change your smile, you would:

- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

One a scale of 1-10 with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your dental visit?

_____

_____

EMERGENCY CONTACT NOT RESIDING WITH YOU:

Name: _____

Relationship: _____

Phone No. :_____

Payment Policy

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the quality care needed to enjoy a healthy and confident smile.

PAYMENT IN FULL
Full payment is required at the time of service from all patients that do not have insurance coverage.

DENTAL INSURANCE
We are happy to file the forms necessary to see that you receive the full benefits of your coverage. We cannot guarantee any estimated coverage. Your unpaid deductible and any estimated portion of fees not covered by your insurance are due at the time of service. Because the insurance policy is an agreement between you and the insurance company, we ask that patients be directly responsible for all charges. If for any reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time.

PAYMENT OPTIONS
- CASH OR CHECK: For fees exceeding $200.00 per patient, we are happy to offer a 5% courtesy adjustment for all treatment paid at the time of service. This excludes Orthodontic care.
- CREDIT CARDS: For your convenience, we have made arrangements to accept payment Visa, Mastercard, AMEX, Discover
- PAYMENT PLANS: For patients who desire a monthly payment plan, we have made arrangements with a finance company. There are no application fees or down payment and the loan can be interest-free. Applications are available from our office and approval is provided quickly.

PAST DUE BALANCES
A past due balance is any amount owed from a prior visit where insurance is not pending or an insurance payment has not been received within 60 days. All unpaid balances are subject to a 1.5% monthly service charge. Any delinquent account will be required to pay all past due balances in full before incurring any new charges. All future charges will need to be paid at the time services are rendered. Severely delinquent accounts will be assigned to a collection agency.

RETURNED CHECKS
Checks returned for insufficient funds will be subject to a $30.00 service fee.

RED FLAG RULE
The Red Flag Rule was created by the Federal Trade Commission, along with other government agencies such as the National Credit Union Administration, to help prevent identity theft. The rule was passed in January 2008. In order to comply with this rule, our office will be requiring the following information in order to be treated in our facility.

1. All new patients will be required to present a valid photo identification card issued by a local, state or federal government agency, and we shall copy said identification to keep in our files:
   a. In the case where the new patient is a minor, photo identification of the patient's responsible party will be obtained; and
   b. In the case where a new patient does not have a valid photo ID, two forms of non-photo identification, one of which is issued by a state or federal agency, will be obtained as well as a water or utility bill or other form identifying the correct or current address.
2. For new patients with insurance, information will be verified with their insurance company prior to billing.
3. If Patient Refuses to Present Identification:
   a. In an emergent situation, we shall refer the patient to the nearest hospital for care;
   b. In a non-emergent situation we shall reschedule the appointment for a later date in which that patient will be required to bring the necessary identification.

You have the right to a paper copy of this notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

Patient Signature: _____ Date: _____