SIX MONTH SMILES®

Cosmetic Braces System

WHAT ASPECTS OF YOUR SMILE WOULD YOU LIKE TO IMPROVE?

____ CROWDING/CROOKED TEETH

____ SPACES

____ TOOTH SHAPE

____ TOOTH SIZE

____ GUMMY SMILE

____ UNDERBITE

____ TEETH ARE DIFFERENT COLORS

____ JAW JOINT PAIN

____ MISSING TEETH

____ DARK TEETH

____ SPEECH PROBLEMS

____ OVERBITE

____ FACIAL PROFILE

____ UGLY OLD CROWNS

____ OTHER _____

I AM INTERESTED IN:

____ SIX MONTH SMILES (Short-term orthodontic treatment)

____ TEETH WHITENING

____ VENEERS

____ OTHER _____

IS THERE ANYTHING YOU WOULD LIKE THE DENTIST TO KNOW?

_____

_____

_____

_____

_____

_____

Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Cell Phone #1 (____) _____ Cell Phone #2 (____) _____

Employer/School _____ Employer/School Phone (____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

– OVER –

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ 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

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

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 the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

The Financial Policy of Kramer Dental PA

Thank you for choosing our office as your dental health care provider. Our primary responsibility is to deliver the best and most comprehensive dental care available. Part of our commitment is your understanding and responsibility for the payment of your account balance.

Our basic financial policy is the following:

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE MANAGER.

WE ACCEPT CASH, CHECK, VISA or MASTERCARD

ADULT PATIENTS

Adult patients are responsible for full payment at the time of service unless specific arrangements are made prior to the start of treatment.

MINOR PATIENTS

The adult accompanying a minor and the parents/guardians are responsible for full payment at time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to by Visa/Mastercard or by cash, check at time of service has been verified.

REGARDING INSURANCE

Full payment is required at time of service, we will accept assignment of participating insurance plans and will submit dental claims on our patient's behalf, and we will submit a refund for payment from an insurance company back to our patients in a timely fashion. We are not able to pre-determine or bill for insurance benefits only. A pre-treatment estimate will need to be submitted to your insurance company to determine the schedule of benefits for the services to be rendered.

Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Any insurance claim not settled within 90 days will be due in full. It's your responsibility to pay our practice in full for the treatment invoice.

Please be aware that some and perhaps all of the services provided may be non-covered services. You are responsible for the entire balance no matter what the outcome is with your insurance provider.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for the quality of the treatment that is rendered. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will do all that is reasonable and proper to have you receive the maximum insurance benefits you are entitled too.

PATIENT RESPONSIBLTY AND ADDITIONAL TERMS

Accounts unpaid after 60 days from day of service are subject to a delinquent fee of $35.00. Furthermore the unpaid balance is subject to a 1 ½% monthly (18% Annual) finance charge. If we have to submit your unpaid account to a collections process you will be responsible for all charges our practice incurs; including collection fees, court costs and reasonable attorney's fees.

MISSED OR LATE APPOINTMENTS/RETURNED CHECKS

Unless appointments are cancelled at least 24 hours in advanced, our policy is to charge for missed appointments. You will be charged a $50.00 **non-refundable** fee. Showing up 30 minutes late for a scheduled, confirmed appointment will carry the same $50.00 **non-refundable** fee.
Any returned check will carry a $40.00 fee.

Thank you for understanding our ***Financial Policy***. Please let us know if you have any questions or concerns.

I have read this ***Financial Policy***. I understand and agree to the terms of the ***Financial Policy of Kramer Dental PA. A picture ID is also required with your signature.***

X _____ Date_____
Signature of Patient or Parent of Minor Patient

X_____ Date_____
Signature of Co-Responsible Party

Patients with Insurance

The treatment estimate being presented to you is only an **Estimate** of what your insurance is expected to pay towards the following treatment. The estimate is based on the information provided to us by you and your insurance company. If your insurance company does not make the estimated payment, it is solely your responsibility to make payment in full to Kramer Dental, P.A. Kramer Dental, P.A. offers insurance claim filing services as a courtesy to our patients, but ultimately it is a contract between you and your insurance company.

I, _____, have fully read and understand the above statement and understand that I am responsible to pay if my insurance company does not pay for any reason.

_____ _____

(Patient, Guardian or Parents signature) (Date)

Authorization for Signature on File

I, _____, hereby authorize Kramer Dental, P.A. to affix my name to any and all claims or documents as related to any and all health benefits due me.
The "Signature on File" will be valid from this date indefinitely for as long as I am a patient of record at Kramer Dental, P.A.

_____ _____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receipt (or read) copy of the current Notice of Privacy Practices on the date stated below. Privacy Practices is a Federal Law basically stating that all personal information will only be shared with the insurance company, or other agency, that is involved with your healthcare. Personal information will not be shared with those parties not involved with your care.

_____ _____

Signature Date