



Patient Information

Welcome to our office! To assist us in serving you, Please complete this confidential form.

Patient name _____ Preferred name _____

SSN: _____ Birthdate _____

If minor, parent names _____

Home phone _____ Work phone _____ Cell phone _____

Email _____

Emergency Contact Name/Phone Number _____

Preferred method of contact (please check) Home Work Cell Email

Mailing address _____ City _____ State _____ Zip _____

Your employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Who may we thank for referring you to our office? _____

Insurance information: Not covered by dental insurance

Name of Insured _____

Insured Social Security Number _____ Insured Date of Birth _____

Dental Insurance Company _____ Group number _____

Covered by spouse's insurance? yes no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Spouse's social _____

Signature of patient (or parent) _____ **Date** _____

Health History

Do you have or have you had any of the following conditions (check all that apply)

| | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Artificial Heart Valve(s) | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Congenital Heart Lesions |
| <input type="checkbox"/> Cough, Persistent or Bloody | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dementia | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding/Bruising | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaw Popping/Pain | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other | <input type="checkbox"/> None |

Allergies- Are you allergic to or have had any adverse reactions to the following (check all that apply)

| | | | | |
|--|---------------------------------------|---------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Cephalexin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Keflex | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Codeine | <input type="checkbox"/> Hydrocodone | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Latex | <input type="checkbox"/> Other | <input type="checkbox"/> None |

Current medication and dosages:

I am not currently taking medications

Are you currently under medical treatment of any kind? Yes No

Are you now or have you ever used a bisphosphonate to treat osteoporosis? (Actonel, Atelvia, boniva, Fosamax) Yes No

Have you been admitted to a hospital or needed emergency treatment within the last 2 years? Yes No

Do you have any health issues that need further clarification? Yes No

Are you pregnant? Yes No Due Date _____

Signature _____ Date _____

Medley Smiles LLC.

HIPAA Signature:

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Medley Smiles.

The Notice Of Privacy Policy provides information about how we may use and disclose your protected health information. We encourage you to read it carefully. The Notice or Privacy Policy is subject to change. If the Notice is changed, you may obtain a revised copy by requesting it from our staff.

Your medical information may be released to the person(s) you authorize below. Authorized person(s) may receive your information regarding treatment, appointments, and collections.

Name of person(s) authorized to call our office on your behalf

I acknowledge receipt of the Notice of Privacy Practices from Medley Smiles LLC.

Signature _____ Date _____

HIPAA is the Federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect confidentiality, and protect the security of your healthcare information.

Financial Policy

Medley Smiles LLC

Thank you for choosing Medley Smiles! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options.

Payment options

- Cash, check, Visa, Mastercard, Discover and American Express
- For our patients who do not have dental insurance, we offer a 10% bookkeeping discount for payments made in full at time of service.
- Care Credit- we offer financing through Care Credit, a third-party lending company. Care Credit specializes in medical, dental, and veterinary care. Medley Smiles offers 6 or 12 month deferred interest plans as well as 18-24 month extended payment plans with low fixed rates.
- GreenSky - we offer financing through GreenSky, a third-party lending company which specializes in technology enabled, simple payment solutions for medical and dental treatment. With GS, we can offer 6 or 12 month deferred interest payment plans, as well as low fixed rates up to 67 months.

Dental insurance

We will do our best to obtain maximum benefits for our patients. It is important to keep in mind that most insurance policies do not pay 100% of the charges incurred, and that many have an annual deductible. Benefits received are dependent on the contract between the insured's employer and the insurance company. Any remaining balance unpaid by the insurance company within 60 days is the responsibility of the patient. Balances over 90 days will be forwarded to a collections agency and assessed an additional charge of 30% of the outstanding balance.

Please Note

- **Medley Smiles requires a deposit, or payment in full, to reserve treatment appointments..**
- **Please give us at least 48 hours notice if you need to cancel or reschedule your appointment. A \$50 fee will be charged per hour scheduled, if this consideration is not given.**
- **Checks returned for insufficient funds will result in an additional \$30 charge**

If you have any questions, please don't hesitate to ask. We are here to help you get the dentistry you want and need.

Patient's name (print) _____

Patient, parent or guardian signature _____ Date _____