MIRACLE SMILE
BEAUTIFUL DENTISTRY

PATIENT REGISTRATION FORM

Thank you for choosing Miracle Smile Dentistry, we deeply care about all of our patients. We strive to offer the highest standards of oral care in the most professional and sensitive manner. If you have any concerns or questions, please let us know.

Reason for your visit: _____ How did you hear about us? _____

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State / Zip: _____ Country: _____

Telephone #1: _____ □ Home □ Work □ Mobile Telephone #2: _____ □ Home □ Work □ Mobile

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □Widowed

Date of Birth: _____ Social Security: _____ Email: _____

Responsible Party (if other than the patient) □ Responsible Party is also the Primary Policy Holder

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State / Zip: _____ Country: _____

Telephone 1: _____ □ Home □ Work □ Mobile Telephone 2: _____ □ Home □ Work □ Mobile

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □Widowed

Date of Birth: _____ Social Security: _____ Email: _____

Insurance Information (if any or if not already given to our office) □ Self □ Spouse □ Child □ Other

Name of Primary Holder: _____ DOB: _____ SS# _____

Insurance Company Name & Phone #: _____ ID#: _____

Employer Name & Phone #: _____ Group#: _____

Patient Questionnaire

Do you like your teeth? □ Yes □ No If no, why? _____

Do your gums bleed? □ Yes □ No

Have you previously received a cleaning? □ Yes □ No When? _____

When was the last time you went to the dentist? _____

Are you interested in Teeth Whitening? □ Yes □ No (Please ask the front desk about our special promotion for new patients)

Are you afraid of going to the dentist? □ Yes □ No □ Terrified

Are you interested in Botox? □ Yes □ No (Please ask the front desk about our special promotion for new patients)

Would you like to hear about our Invisalign Promotion this month? □ Yes □ No

In what language do you prefer to speak? _____

Signature: _____ **Date:** _____

FINANCIAL POLICY & GENERAL CONSENT FOR DENTAL TREATMENT

(PLEASE READ CAREFULLY)

FINANCIAL POLICY

Financial arrangements must be made in advance. We accept cash, personal checks, cashier's check, money orders, Visa, MasterCard, Discover and American Express. We also offer alternative payment plans (based on approval) as an option for financial arrangements. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. All treatment plans presented are valid only for 3 months unless otherwise stated.

GENERAL CONSENT FOR DENTAL TREATMENT

I hereby authorize Miracle Smile Dentistry's staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my/my child's dental needs. Upon such diagnosis, I authorize this office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I grant my permission to telephone me at home, work or cell to discuss matters related to this form, appointments and treatment. I understand and acknowledge that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes and I agree to the same. I authorize dental benefits to be paid directly to Miracle Smile Dentistry.

I understand my dentist reserves the right where appropriate to provide me with a more specific consent for some dental treatments. I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to not receive treatment although that carries with it its own risks. I am aware that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that routine fillings, dental cleanings, and prescription of medications may cause temporary soreness, tooth sensitivity, and unusual reactions/allergies to medications given or prescribed. Further, if I am taking medications these could have an adverse interaction, and I need to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements. I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction, or temporary or permanent injury to the nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of a post operative infection, nerve damage, and iatrogenic injury. In rare cases, the complications from surgery can be permanent, disabling, or even causing death. I understand the infection area(s) may be uncomfortable following treatment and that my jaw may be stiff and/or sore from holding my mouth open during treatment. I understand that all treatments and procedures have a risk of separation of dental instruments which my become lodge in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment I will contact the treating dentist at Miracle Smile Dentistry.

I understand that the practice of dentistry is not an exact science and my dentist cannot offer any guarantees or assurances as to the outcome or result of the treatment or surgery. I have the right to ask the treating dentist for more information if I have concerns about my procedures and the possible side effects or complications. I promise to use that right to its fullest intent if for any reason I feel I am not fully informed about my procedure, the risk of the procedure, and my alternatives.

I have read the above conditions of treatment and payment and agree to their content.

_____

Patient/Guardian Signature | Relationship to Patient | Date

APPOINTMENT CANCELATION POLICY

Please understand that a missed appointment incurs expenses to our office. We value your time and we expect that you value ours. We understand that sometimes circumstances come up that cause patients to miss appointments.

If for some reason you cannot come to your scheduled appointment, please let us know 48 hours in advance; otherwise a **$50 missed appointment fee** will be charged to your account.

I have read the above conditions and agree to their content.

_____

Patient/Guardian Signature Relationship to Patient Date

NOTICE TO PATIENTS WITH INSURANCE

Please understand that our service for processing your claims is a courtesy and not our obligation. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Every plan design is deferent for every employer group. Your dental insurance is a benefit provided by your employer and the contract is between the patient, the employer and the insurance company, not the dentist.

Your insurance wants us to let you know that a predetermination of benefits is not a guarantee of coverage. We will do our best to process your claim successfully. Your copayment is due at the time of treatment and benefits will only be paid by the insurance once they receive and process the claim. Unpaid benefits, if any, will be the patient's responsibility. **Claims taking more than 30 days to process will need to be paid by the patient or responsible party and we will refund as soon as we receive payment from your insurance.**

As a courtesy our staff will assist you with any questions you may have in regards to your insurance.

I have read the above conditions and agree to their content.

_____

Patient/Guardian Signature Relationship to Patient Date