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 "laughing gas" better known Nitous oxide Yes _ No_

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:** ______________

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MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________________

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 If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: ______________________
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: ______________________
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: ______________________
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No ______________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No ______________________
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ______________________

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	○	○	Cortisone Medicine	○	○	Hemophilia	○	○	Radiation Treatments	○	○
Alzheimer's Disease	○	○	Diabetes	○	○	Hepatitis A	○	○	Recent Weight Loss	○	○
Anaphylaxis	○	○	Drug Addiction	○	○	Hepatitis B or C	○	○	Renal Dialysis	○	○
Anemia	○	○	Easily Winded	○	○	Herpes	○	○	Rheumatic Fever	○	○
Angina	○	○	Emphysema	○	○	High Blood Pressure	○	○	Rheumatism	○	○
Arthritis/Gout	○	○	Epilepsy or Seizures	○	○	High Cholesterol	○	○	Scarlet Fever	○	○
Artificial Heart Valve	○	○	Excessive Bleeding	○	○	Hives or Rash	○	○	Shingles	○	○
Artificial Joint	○	○	Excessive Thirst	○	○	Hypoglycemia	○	○	Sickle Cell Disease	○	○
Asthma	○	○	Fainting Spells/Dizziness	○	○	Irregular Heartbeat	○	○	Sinus Trouble	○	○
Blood Disease	○	○	Frequent Cough	○	○	Kidney Problems	○	○	Spina Bifida	○	○
Blood Transfusion	○	○	Frequent Diarrhea	○	○	Leukemia	○	○	Stomach/Intestinal Disease	○	○
Breathing Problem	○	○	Frequent Headaches	○	○	Liver Disease	○	○	Stroke	○	○
Bruise Easily	○	○	Genital Herpes	○	○	Low Blood Pressure	○	○	Swelling of Limbs	○	○
Cancer	○	○	Glaucoma	○	○	Lung Disease	○	○	Thyroid Disease	○	○
Chemotherapy	○	○	Hay Fever	○	○	Mitral Valve Prolapse	○	○	Tonsillitis	○	○
Chest Pains	○	○	Heart Attack/Failure	○	○	Osteoporosis	○	○	Tuberculosis	○	○
Cold Sores/Fever Blisters	○	○	Heart Murmur	○	○	Pain in Jaw Joints	○	○	Tumors or Growths	○	○
Congenital Heart Disorder	○	○	Heart Pacemaker	○	○	Parathyroid Disease	○	○	Ulcers	○	○
Convulsions	○	○	Heart Trouble/Disease	○	○	Psychiatric Care	○	○	Venereal Disease	○	○
									Yellow Jaundice	○	○

Have you ever had any serious illness not listed above? ○ Yes ○ No ______________________

Comments: ______________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ 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.

DELINQUENT ACCOUNTS

The undersigned acknowledges that all accounts are due and payable within 30 days of the invoice date. An interest charge of 1.5% per month will be applied to any unpaid balance. In the event this account is in default and your file is placed with a collection agency, a charge up to 50% of the amount owed will be added to your account and will be your responsibility to pay. You also agree to pay all court costs and attorney fees, whether suit is filed or not. In the event that suit is filed, venue will be Broward County, Florida. The undersigned gives Miracle Smile Dentistry and/or its agents permission to text or email information regarding this agreement.

Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

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 **$100 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 different 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.**

The following is how we work with you regarding your insurance benefits.

- You, the patient, are responsible for the entire treatment fee regardless of insurance benefits. We ESTIMATE your portion and deductible to be paid at time of treatment.
- Our office accepts most PPO insurance plans. We will ESTIMATE co-payments, deductibles and patient portions at the time treatment plans are presented. We cannot guarantee estimated co-payments as payment in full.
- We reserve the right to bill for unforeseen circumstances such as Calendar Year Maximums, Non-Covered services, Non-Duplication Clause or Alternate Benefit Clauses. As the insured employee, you are responsible for knowing and understanding your own insurance contract. Please verify your insurance benefits with your insurance carrier.

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

Patient/Guardian Signature | Relationship to Patient | Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH IMFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

*CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **MIRACLE SMILE DENTISTRY/ ANNA ALLER D.M.D.,** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de with* **MIRACLE SMILE DENTISTRY/ ANNA ALLER D.M.D., *y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

Patient Name: *(please print)* ______________________________
Nombre Del Paciente: *(nombre en letra de molde por favor*

Patient Signature *(or legal representative; proof may be requested)* ______________________________
Firma Del Paciente: *(o representante legal; prueba puede ser requerida)*

Date: *(dd/mm/yy)* ____________________
Fecha: *(dd/mm/aa)*

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **MIRACLE SMILE DENTISTRY/ ANNA ALLER D.M.D., (MSD/AADMD)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **MSD/AADMD** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **MSD/AADMD** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **MSD/AADMD** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **MIRACLE SMILE DENTISTRY/ ANNA ALLER D.M.D, (MSDAADMD)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **MSDAADMD** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **MSDAADMD** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **MSD/AADMD** y yo y consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

My Consented Email Address is: ______________________________
***Mi Correo Electrónico Consentido es:**

My Consented for Text Messaging to: ______________________________
***Mi Mensaje de Textos consentido a:**

X____________________
Patient Signature *** Firma del Paciente**

____
Date ***Fecha**

Cancellation Policy

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 a need arises to cancel or reschedule your appointment, please let us know 48 hours in advance; otherwise a **$100 missed appointment fee** will be charged to a credit card that will be on file.

Please note that failure to comply with our cancellation policy or miss more than three appointments may result in a dismissal from our office.

Please complete the information below:

I ___________ understand that Miracle Smile Dentistry will charge my credit card $100 if I do not make it to my appointment/cancel less than 48 hours prior to my appointment. I understand that I may lose my privileges to have further appointments if I fail to comply with the cancellation policy in effect or miss more than three appointments.

Credit Card Authorization Form:

Card type: VISA ☐ MasterCard ☐ AMEX ☐ Discover ☐

Cardholder name ________________________

Credit Card # ________________________

Expiration date ________________________

Security code ________________________

Billing address ________________________

City, state, zip ________________________

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

Patient/Guardian Signature ________________________

Relationship to Patient ________________________

Date ____________

CONSENT FORM FOR COVID-19

Your health and well-being is our top priority. In response to the Coronavirus Pandemic, we are closely following and adhering to precautions advised by the Center for Disease Control (CDC), Florida Department of Public Health and the American Dental Association (ADA).

All patients will be screened for risks of COVID-19 before their appointments. Individuals with symptoms of respiratory infection (fever, cough, shortness of breath, flu-like symptoms), and individuals who have come into contact with a person with known COVID-19 within the past 14 days, or who have traveled in areas where there is wide community spread of COVID-19, should not be seen at the office at this time.

You are receiving dental care during the events of a COVID- 19 pandemic. Please be advised that there may be risks in being in proximity of dentists, patients or staff. We are taking precautions to limit the spread of disease, yet there is a still possibility of transmission.

Upon starting your appointment we kindly ask that you follow these guidelines:

- We request only patients with scheduled appointments enter the office wearing facemasks.
- Please use good hand hygiene, either washing your hands with soap and water for 20 seconds or by using hand sanitizer.
- Avoid touching your eyes, nose and mouth with unwashed hands.
- Cover your coughs and sneezes by coughing/sneezing into your elbow. Clean your hands after coughing or sneezing.

We want to assure you that we are taking continuous steps to ensure that our office remains a safe place for every patient. It's important for you to know that dentists are experts in infection control. For instance, we have been trained to prevent the spread infectious diseases such as the flu, HIV, hepatitis, and tuberculosis. The precautions we take every day will also help prevent the spread of coronavirus.

Patient's (or Legal Guardian's) Signature: ______________________________

Patient's (or Legal Guardian's) Name: ______________________________

Today's Date: ________________