SKELLYSMILES
FAMILY, COSMETIC & IMPLANT DENTISTRY

Today's Date: _____

Please complete the following patient and family information. Should you have any questions, please just ask! Thank you.

Patient Information

Patient Name: _____ Preferred name: _____

Gender: ☐ Male ☐ Female Are you ☐ Single, ☐ Partnered, ☐ Married, ☐ Widowed, or ☐ Child

Date of Birth: _____Social Security #: _____

Street Address (including Apt #): _____

City: _____ State: _____ Zip Code: _____

Employer Name: _____ Occupation: _____

Whom may we thank for referring you to our practice?

☐ Patient/Friend/Relative: _____

☐ Dental Office ☐ Yellow Pages ☐ Insurance ☐ Internet/Website ☐ Other: _____

For Children 18 and Under: Parent/Guardian Information

Parent/Guardian Name: _____

Gender: ☐ Male ☐ Female Are you ☐ Single, ☐ Partnered, ☐ Married, or ☐ Widowed

Date of Birth: _____Social Security #: _____

Street Address (*can write same if same*) _____

City: _____ State: _____ Zip Code: _____

Insurance Information – Please bring your insurance card to your appointment.

If no insurance card issued we need the subscriber's social security number and date of birth.

Insurance Plan Name: _____

Insurance Plan ID# *(If none, we need the subscriber's social security number*) _____

Insurance Plan Group # _____ Insurance Phone Number# _____

Do you have coverage from a secondary dental insurance plan? ☐ Yes ☐ No

Please complete the following if you are insured under someone else's insurance:

Insured person's relationship to you/the patient: ☐ Spouse/Partner ☐ Parent/Guardian

Name of Insured: _____

Insured's Birthdate: _____ Insured SS # _____

Insured's Employer Name: _____ Occupation: _____

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Please complete the following medical/dental history. Thank you!

Name: _____ **Date of Birth:** _____

Reason for visit: _____ Are you in pain? ☐ Yes ☐ No

Approximate date of last dental visit: _____ Type of Appointment ☐ Check Up ☐ Dental Work ☐ Emergency

Name of medical doctor: _____ City/State: _____

Please list any medications you are taking: ***(or provide a list we may copy)***

_____ _____

_____ _____

_____ _____

Are you allergic/sensitive to any of the following?

☐ Yes ☐ No	**Local Anesthetic "*Novacaine*"**	☐ Yes ☐ No	**Latex**
☐ Yes ☐ No	**Aspirin**	☐ Yes ☐ No	**Penicillin**
☐ Yes ☐ No	**Codeine**	☐ Yes ☐ No	**Sulfa**
☐ Yes ☐ No	**Ibuprofen**	☐ Yes ☐ No	**Gluten Sensitivity**
☐ Yes ☐ No	**Epinephrine**	**Others**: _____	

Do you have or have you had in the past any of the following medical conditions?

☐ Yes ☐ No	**Asthma**	☐ Yes ☐ No	**Heart Murmur**	☐ Yes ☐ No	**Heart Surgery**		
☐ Yes ☐ No	**Bleeding Problems**	☐ Yes ☐ No	**Artificial Heart Valves**	☐ Yes ☐ No	**Heart Attack**		
☐ Yes ☐ No	**Cancer**	☐ Yes ☐ No	**High Blood Pressure**	☐ Yes ☐ No	**Psychiatric Treatment**		
☐ Yes ☐ No	**Diabetes**	☐ Yes ☐ No	**Joint Replacement**	☐ Yes ☐ No	**Allergy/Sinus Trouble**		
☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No	**Rheumatic Fever**	☐ Yes ☐ No	**Acid Reflux/GERD**		
☐ Yes ☐ No	**Anemia**	☐ Yes ☐ No	**Hepatitis**	☐ Yes ☐ No	**Kidney Disease**		
☐ Yes ☐ No	**Rheumatoid Arthritis**	☐ Yes ☐ No	**Immunologic Conditions**				

☐ Yes ☐ No **Taken Bisphosphonate Medications (ex: Boniva, Actonel, Fosamax) For Arthritis Or Cancer Treatment**

Other conditions/syndromes not described above, please describe below: ☐ Yes ☐ No

_____

Tobacco Use

Do you Smoke Cigarettes?	☐ Yes	☐ No	☐ Previously, have quit
Do you Smoke Cigars?	☐ Yes	☐ No	☐ Previously, have quit
Do you use 'Smokeless Tobacco', "Chew" or "Snuff"	☐ Yes	☐ No	☐ Previously, have quit

Do you have any concerns about dental treatment you'd like us to know about?

_____

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Patient Communication Preferences and Consent

Patient Name: _____ Date of Birth: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Other Number: (describe) _____

E-mail address: _____

Would you prefer to receive your appointment reminders via ***(Circle all that apply):***

…Text message …Home Phone

…E-mail …Work Phone

Standard text messaging fees may apply-based on your mobile phone service

I give permission for Skelly Smiles to call and identify them as calling from Skelly Smiles and leave detailed information regarding my appointment schedule, prescriptions, outstanding balance or care on my answering machine, cell phone voice mail or work voice mail, as designated below: By providing my cell phone number, I authorize Dr. Skelly and her staff members to contact me via my cell phone.

Home phone #_____ Ok to leave a message ☐ Yes ☐ No

Work phone # _____ Ok to leave a message ☐ Yes ☐ No

Cell phone # _____ Ok to leave a message ☐ Yes ☐ No

I also give permission for Skelly Smiles to speak to the following person(s):

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Emergency Contact Person

_____ Phone Number: _____

Consent

I certify that all the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic. I understand that I will be informed of any treatment changes as they occur. I will assume responsibility for fees associated with all procedures and costs incurred in the collection of those fees.

Patient ***(Parent/Guardian if under 18)*** _____ **Date:** _____

Acknowledgement of Receipt of our Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of privacy Practices.

Print Names: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice or Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please Specify): _____

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Privacy Statement. Our Commitment to You.

- We will safeguard with strict confidentiality any personal health information that you share with us
- Our employees are trained in privacy practices
- We do not provide patient list for any vendor or unaffiliated third parties

We Do:

- Send information and x-rays of your condition to your dental insurance (i.e. for a fixed bridge prosthesis, filling, crown) including your name and address
- Review your pertinent health information with other physician, dentist or specialist that could be involved with your treatment either written or orally
- Intra-office review of information between our staff members

HIPPA Regulations

These are new federal regulations that require us to notify you that your health, dental and other information may be used for treatment, payment and general operations.

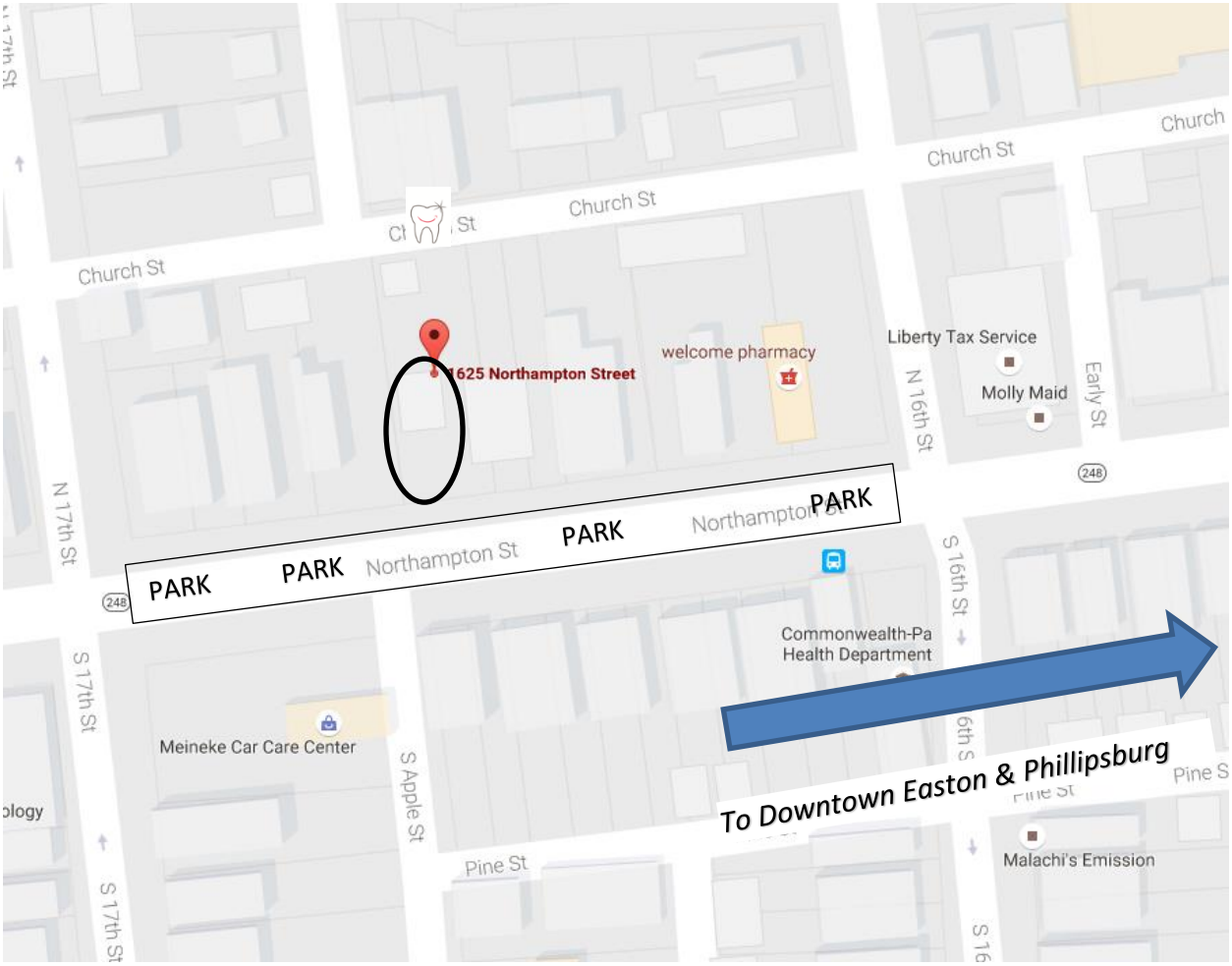
We must make the effort to secure your acknowledgement of receipt of this notice

This form, "Notice of privacy Practices", presents the information that the federal law requires us to make available to our patients regarding our privacy practices. (New regulations effective April 14, 2003).

We must provide this Notice to each patient. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of the service delivery and to any person request a Notice. We must also post the revised Notice in our office as discussed above.

Directions to Skelly Smiles

Skelly Smiles is conveniently located at 1625 Northampton Street in a recently renovated two story free-standing building. The exterior is white siding with black trim. Our signage is visible from the street. Our office is handicapped accessible with two steps to access the front entrance with a railing and a ramp up to the door. There is free street parking on either side of the street.



From Points North and West: Exit 33S for 22E towards Easton. Exit at Wilson 248 Exit. Continue straight through traffic light. Follow road past Burger King and Wendys to light. Make right onto Northampton Street at the light. We are between 17th and 16th Streets on the left hand side, halfway between the block.

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Our Financial Policy

It is the goal of all of us here at Skelly Smiles to provide you optimal dental health by offering quality dental care through treatment options and financial arrangements that meet your individual needs. **Payment is due at the time of service**, except for the portion of fees in which payment from an individual insurance plan can be sent directly to us.

For your convenience, we accept:

- Cash
- Check
- Visa, MasterCard, Discover, and American Express Cards
- Care Credit Payment Plan
    - If you desire a payment plan after discussing treatment options with the doctor and do not wish to use a credit card, our staff will be happy to explain how this special line of credit for dental treatment works and will help you with the simple application process.

Insurance Payments: Our staff will help you to understand your insurance policy and maximize your plan's benefits to achieve your treatment goals. **You are responsible for any deductibles, copayments, or maximum overages that occur with your policy**. **There may be waiting periods with new insurance plans. Please be cautious that if services are rendered and insurance covered isn't effective, you are responsible for the cost of treatment.** It is your responsibility to inform us of any insurance policy changes at or before the time of your appointment. Ultimately, you are responsible for the services you receive, and if the insurance has not remitted payment you are responsible for the total cost.

Returned checks are subject to a $35.00 returned check fee.

Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued, and is overdue if not paid by twenty-one (21) days after the statement

A finance charge will be imposed on each item of your account which has not been paid within 90 days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of (1.0%) per month or an ANNUAL PERCENTAGE RATE of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1.0%) to the "overdue balance of your account. The "overdue balance" of your account is calculated by taking the balance owed ninety (90) days ago, and then subtracting any payments or credits applied to the account during that time.

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred.