KELLY SMILE

IMPECCABLE CARE WITH AN ARTISTIC EYE

Cosmetic & Restorative Dentistry

NAME:_____

WELCOME TO KELLY SMILE DENTISTRY!

*How did you hear about us?

____ Insurance Referral

____ Google (Internet)

____ Yelp

____ Direct Mail (Postcard)

____ TV

____ Newspaper

____ Magazine

____ Social Media

____ Professional Referral

____ Friend/Family: Whom may we thank for referring you?

_____

____ Other:_____

Thank you for your answer!

TMJ HEALTH QUESTIONNAIRE

Date_____

Name:_____
Birth Date:_____

PAIN SYMPTOMS

Do you get headaches? Y N
Do you get migraine headaches? Y N
Do you frequently have neck aches or stiff neck muscles? Y N
Have you ever had chronic shoulder or back pain? Y N
Do you have trouble sleeping soundly? Y N
Are your jaws tired when you awaken? Y N
Are your teeth sore when you awaken? Y N

Have your wisdom teeth been extracted? Y N

What medications, if any are you taking?
_____

Do you get headaches in the left temple areas? Y N
Do you get headaches in the front or back of your head? Y N
Do you clench your teeth during the day? Y N
Do you clench your teeth at night? Y N
Do you grind your teeth when asleep? Y N

When are your pain symptoms the worst?
_____

Does anything make you feel better?
_____

How often do you take medication for relief of pain?
_____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw? Y N
Any whiplash neck injuries? Y N

Have you ever been involved in any serious accidents, such as car accident? Y N
Details_____
_____

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y N
Are there any foods you avoid eating? Y N
Do you ever get dizzy? Y N
Do you ever feel faint? Y N
Do you ever feel nauseated? Y N
Is there a family history of jaw joint? Y N

Do you feel or hear a 'clicking', popping or 'cracking' noise from either joint? Y N
Has your jaw ever locked when you were unable to open or close? Y N
Do you have difficulty opening wide or yawning? Y N
Does your jaw ache when you open wide? Y N

EAR AND EYE SYMPTOMS

Do you have pain in either ear? Y N
Do you suffer from any loss of hearing? Y N
Do you have itchiness or stuffiness? In either ear? Y N

Do you wear glasses or contacts? Y N
Are there times when your eyesight blurs? Y N
Do you get pain in around or behind either eye? Y N

BREATHING

Do you have allergies? Y N
Do you have sinus problem? Y N
Do you snore at night? Y N

Is your nose stuffed when you don't have a cold? Y N
Have you been diagnosed with Sleep Apnea? Y N
Have you had a sleep study done at a Sleep Clinic (hospital) Y N

Signature_____

Date_____

KELLY SMILE DENTISTRY

Patient X-Ray and Dental Record Transfer Policy:

X-RAYS: REGULAR X-RAYS($50), 3D SCAN/PANO($200)

All patients may request their own or their child's x-rays (parent or guardian) in person with a valid driver's license with photo or a valid government ID with photo (a copy will be made and retained at our office) by completing a RECORDS RELEASE AUTHORITY FORM. Your X-Rays will be sent certified mail with signature confirmation to the address you designate in writing. **Note: X-Rays printed most likely will not be of diagnostic quality and we are not responsible if the dentist interpreting the X-Rays require you to take new ones to be diagnostic. We will not pay for your new X-Rays. X-Rays received by mail, fax or email to our office are not diagnostic quality and must be taken at our office at the patient's cost.** (Please allow two weeks to process.) (The fee for this service is $50.00/$200 payable to KELLY SMILE DENTISTRY.)

A dental office other than the local dental specialists we have a relationship and refer may request on your behalf your dental x-rays. A RECORDS RELEASE AUTHORITY FORM must be completed by the patient requesting the release in person at our office or in writing with a copy of a valid driver's license with a photo of the patient. Those x-rays will be sent to your new dentist by mail after the doctor and place of business has been verified. This record will be sent mail with signature confirmation. (Please allow two weeks to process.)(The fee for this service is $50.00/$200 payable to KELLY SMILE DENTISTRY.)

In-Person Pick-up of X-Rays or Dental Records:

Please allow two weeks to process and the patient must follow the protocol listed above.

Emailing and Faxing of X-Rays or Dental Records:

It is our policy **not** to email x-rays and fax records to unknown parties such as a another dentist, physician, or hospital for your security and privacy even though all our professional emails are encrypted that are sent from Kelly Smile Dentistry .

Dental Record:

A patient's dental record can be requested by the patient with the completion of a RECORDS RELEASE AUTHORITY FORM and a formal request in writing describing what specific records you are requesting from our office, a copy of a valid driver's license with a photo even if in person must accompany the request and the address you would like it sent. This record will be sent mail with signature confirmation. (Please allow two weeks to process.)(The fee for this service is $50 payable to KELLY SMILE DENTISTRY.)

By signing below, I have read, understand and all my questions have been answered:

_____ _____ _____

Print Name Signature Date

KELLY SMILE DENTISTRY
12120 RIDGECREST RD., SUITE 203
VICTORVILLE, CA 92395
760.242.2338
DRKELLYSMILE2@GMAIL.COM

OFFICE PAYMENT, APPOINTMENTS AND INSURANCE POLICY

We strive to provide excellent care, skill and judgement and in return, we ask for help in paying for our services in a responsible and timely manner. Please feel free to ask any questions regarding this policy.

- **CONTRACTED INSURANCE:** All contracted insurance companies are billed directly as a courtesy. We require that the deductible, co-payments and non-covered benefits be paid for on the day services are rendered. In general, benefits should be assigned to us. Insurance policies do not guarantee any payments. The payment toward any changes may vary. Any remaining balances after insurance payments are your responsibility. Payment is expected within 30 days from receipt of your statement.
- **NON-PAYS:** All co-pays are expected at the time service is rendered.
- **NON –CONTRACTED INSURANCE:** All Third Party Payers (motor vehicle accident insurance) are considered non-contracted.
- **METHOD OF PAYMENT:** We accept cash, checks, Visa, MasterCard, American Express , Discover and CareCredit.
- **PAYMENT ARRANGEMENTS:** We understand that there may be times when financial difficulties come upon us without warning. Under special circumstances temporary payment arrangements may be made if approved in advance. Accounts on a temporary payment plan are required to make payment every month. Missed payments may result in collections. Accounts on a payment plan must continue to pay at the time of service. Our goal is to help you from attaining a greater debt and to assist you in keeping your account in a manageable level.
- **RETURNED CHECKS:** There is a **$75.00** fee for all returned checks.
- **SERVICE FEE:** There is an interest fee accrued on all accounts (up to 22% per annum) with balances 60 days and over, regardless of payment arrangements or secondary insurance status.
  If the account is sent to collections, you will be responsible for all related collection fees and interest added to your account.
- **NO SHOW/CANCELLATION POLICY:** There is a **$100.00** fee for no-show appointments or cancellation appointments without 48-hour notice.
- **DUPLICATION OF DENTAL RECORDS & X-RAYS:** There is a **$50.00** fee for copy of X-rays.

I understand that the office will submit all claims to my insurance company on my behalf. I also understand that it is my responsibility to pay for all fees for services rendered. I authorize payment of dental benefits to the doctor for services provided to me /and or any members of my family covered under my insurance plan.

I HAVE FULLY READ, UNDERSTAND AND CONSENT TO ALL OF THE ABOVE TERMS.

PATIENT NAME_____

PATIENT SIGNATURE_____ DATE: _____

WITNESS (OFFICE STAFF):_____DATE:_____

KELLY SMILE DENTISTRY

PATIENT-DENTIST ARBITRATION AGREEMENT

ARTICLE I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would be determined by submission to arbitration proceedings. Both parties of this contract by entering into it, have given up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

ARTICLE II.

A. Parties to the Agreement

The term "patient as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "doctor" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to full extent permitted by law.

B. Treatment Covered:

Patient understands and agrees that any dispute of the sort descried in Article I between doctor and patient will be subject to compulsory, binding arbitration.

C. Coverage of Pre-Natal Claims (If Applicable):

Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort descried in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

ARTICLE III.

A. Informed Resolution of Disputes:

In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running or statute of limitations for ninety (90) days.

B. Method of Initiating Arbitration:

If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection of the arbitrator, arbitration must be held within thirty (30) days.

C. Applicable Law:

The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.

The arbitrator shall not have the power to commit errors of law or legal reasoning, and the arbitrator's decision may be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error.

The Prevailing party shall be entitled to attorney fees.

ARTICLE IV.

A. Revocation:

If you are signing this agreement and then change your mind,, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREENING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY MUTUAL ARTIBRATION AND YOU ARE GIVING UP RIGHT TO JURY OR COURT TRIAL, SEE ARTICLE I OF THIS CONTRACT.

PATIENT'S NAME: (PLEASE PRINT): _____

DATE: _____

SIGNED: _____

SIGNED: _____
PARENT/LELGAL GAURDIAN

SIGNED: _____
WITNESS

12120 RIDGECREST RD., SUITE 230
VICTORVILLE, CA 92395

Dental Information Release Form

I, _____give permission to Dr. Kelly Hong and staff at Kelly Smile to share dental information with_____.

Signature _____ Date_____.

Patient Information

Name:_____

Address:_____

City, State, Zip:_____

Phone:_____ Date of Birth:_____

KELLY SMILE

IMPECCABLE CARE WITH AN ARTISTIC EYE

Cosmetic & Restorative Dentistry

Cancellation Policy/No Show Policy

We understand there are times when you miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 48 hours in advance you will be charged a $100.00 fee.

_____	_____	_____
Patients Name (Print)	Signature Patient /Guardian	Date

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Cosmetic & Restorative Dentistry

Patient Acknowledgement

Acknowledgement Receipt of Dental Materials Fact Sheet

By signing this form, you acknowledge receiving from Kelly Smile Dentistry a copy of the Dental Materials Facts Sheet dated on 05/2004. If you have any questions about the Dental Materials Facts Sheet, please contact our office at (760)242-2338.

Patient Name: _____

Date of Birth: _____

Signature of patient/ legal representative: _____

Date: _____