



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!

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: Policy Holder Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Gender: Male Female Unknown

Marital Status: Married Single

Divorced

Separated

Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

Drivers Lic: _____

E-mail: _____

I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time

Part Time

Retired

Student Status: Full Time

Part Time

Medicaid ID: _____

Prof. Dentist: _____

Employer ID: _____

Prof. Pharmacy: _____

Carrier ID: _____

Prof. Hyg: _____

Referred By _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

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, c

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

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

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

Have you ever had any serious illness not listed above? Yes No If yes

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:

X

Date: _____

Kelly Smile Dentistry
12120 Ridgecrest Rd. Suite 203
Victorville, CA 92395
(760) 242-2338 Fax: (760) 684-4800

PATIENT PRIVACY ACT

PATIENT INFORMATION

Name: _____

Date of Birth: _____

YOUR HEALTH INFORMATION RIGHTS

You have the right to request restrictions on certain uses of your health information. Please be advised however, that Kelly Smile Dentistry is not required to agree to the restrictions that you request.

You have the right to have your health information received or communicated through alternative method or location other than the usual communication or delivery, upon request.

You have the right to inspect and copy your health information.

You have the right to request Kelly Smile Dentistry amend your protected health information. Please be advised, that Kelly Smile Dentistry is not required to agree to amend your protected health information. If your request to amend your health information had been denied, you will be provided with an explanation of our dental reason(s) and information about how you can disagree with the denial.

You have the right to receive an accounting of disclosures of your protected health information made by Kelly Smile Dentistry.

You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

Kelly Smile Dentistry is required by law to maintain the Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Kelly Smile Dentistry is required by law to comply with this Notice.

Kelly Smile Dentistry is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any notice or if you want more information about your privacy rights please contact: Kelly Smile Dentistry by calling this office at (760) 242-2338. If Kelly Smile Dentistry is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

COMPLAINTS

Complaints about your Privacy Rights or how Kelly Smile Dentistry has handled your health information should be directed to Kelly Smile Dentistry by calling out office at (760) 242-2338. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS OFFICE OF CIVIL RIGHT - 200 Independence Ave., S.W. Room 509F HHH Building Washington, DC 20201

This notice effective as of today's date listed below.

I have read the Privacy Notice and understand my rights contained in the notice. By signing this form, I provide Kelly Smile Dentistry my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

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.
- **NO SHOW/CANCELLATION POLICY:** There is a \$50.00 fee for no-show appointments or cancellation appointments without **48-hour notice**.
- **GRACE PERIOD:** As a courtesy to all our patients, we will allow a **15-minute grace period** after your appointment time. Patients who arrive within the grace period will be seen as scheduled; however, appointment time may be shortened to avoid delays for other patients. Patients who arrive after the grace period will be considered or rescheduled and will incur a \$50.00 broken appointment fee.
- **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:** _____