Patient Information

Welcome to our office! To assist us in serving you, Please complete this confidential form.

Patient name ______________________________________ Preferred name__________________

SSN:_________________________________ Birthdate ________________

If minor, parent names____

Home phone_________________Work phone_________________Cell phone________________

Email______________________________

Emergency Contact Name/Phone Number ____

Preferred method of contact (please check) __Home __Work __ Cell__ Email__

Mailing address__________________________City___________State _______Zip ____________

Your employer__________________________________Occupation_________________________

Spouse's name _________________________ Spouse's employer _________________________

Who may we thank for referring you to our office?____

Insurance information: ______Not covered by dental insurance

Name of Insured_________________________________

Insured Social Security Number___________________ Insured Date of Birth _______________

Dental Insurance Company___________________________Group number___________________

Covered by spouse's insurance? _____yes ______no

Spouse's dental insurance company_______________________Group number_______________

Spouse's birthday _________________________ Spouse's social_________________________

Signature of patient (or parent)______________________________**Date**___________________

Health History

Do you have or have you had any of the following conditions **(check all that apply)**

AIDS/HIV	Anemia	Arthritis, Rheumatism	Artificial Heart Valve(s)	Artificial Joints
Asthma	Back Problems	Blood Disease	Blood Thinner	Blood Transfusion
Cancer	Chemical Dependency	Chemotherapy	Cold Sores/Fever Blisters	Congenital Heart Lesions
Cough, Persistent or Bloody	Diabetes	Dementia	Dizziness/Fainting	Emphysema
Epilepsy	Excessive Bleeding/Bruising	Glaucoma	Head Injury	Heart Murmur
Heart Problems	Hepatitis	High Blood Pressure	Jaw Popping/Pain	Kidney Disease
Liver Disease	Low Blood Pressure	Mitral Valve Prolapse	Pacemaker	Psychiatric Care
Radiation Therapy	Sinus Problems	Stroke	Swelling	Thyroid Problems
Tobacco Use	Tonsillitis	Tuberculosis	**Other**	**None**

Allergies- Are you allergic to or have had any adverse reactions to the following **(check all that apply)**

Amoxicillin	Cephalexin	Erythromycin	Keflex	Penicillin
Tylenol	Barbiturates	Codeine	Hydrocodone	Ibuprofen
Local Anesthetics	Sulfa	Latex	**Other**	**None**

Current medication and dosages: **_____ I am not currently taking medications**

____

____

Are you currently under medical treatment of any kind? _____ Yes ______ No

Are you now or have you ever used a bisphosphonate to treat osteoporosis? (Actonel, Atelvia, boniva, Fosamax) _____ Yes _____ No

Have you been admitted to a hospital or needed emergency treatment within the last 2 years? ____ Yes _____ No

Do you have any health issues that need further clarification? _____ Yes _____ No

Are you pregnant? ____ Yes _____ No Due Date__________________

Signature____ Date____

Medley Smiles LLC.

HIPAA Signature:
By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Medley Smiles.
The Notice Of Privacy Policy provides information about how we may use and disclose your protected health information. We encourage you to read it carefully. The Notice or Privacy Policy is subject to change. If the Notice is changed, you may obtain a revised copy by requesting it from our staff.

Your medical information may be released to the person(s) you authorize below. Authorized person(s) may receive your information regarding treatment, appointments, and collections.

Name of person(s) authorized to call our office on your behalf

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I acknowledge receipt of the Notice of Privacy Practices from Medley Smiles LLC.

Signature_________________________________ Date_________________________________

HIPAA is the Federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect confidentiality, and protect the security of your healthcare information.

Financial Policy

Medley Smiles LLC

Thank you for choosing Medley Smiles! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options.

Payment options

- Cash, check, Visa, Mastercard, Discover and American Express
- For our patients who do not have dental insurance, we offer a 10% bookkeeping discount for payments made in full at time of service.
- Care Credit- we offer financing through Care Credit, a third-party lending company. Care Credit specializes in medical, dental, and veterinary care. Medley Smiles offers 6 or 12 month deferred interest plans as well as 18-24 month extended payment plans with low fixed rates.
- GreenSky - we offer financing through GreenSky, a third-party lending company which specializes in technology enabled, simple payment solutions for medical and dental treatment. With GS, we can offer 6 or 12 month deferred interest payment plans, as well as low fixed rates up to 67 months.

Dental insurance

We will do our best to obtain maximum benefits for our patients. It is important to keep in mind that most insurance policies do not pay 100% of the charges incurred, and that many have an annual deductible. Benefits received are dependent on the contract between the insured's employer and the insurance company. Any remaining balance unpaid by the insurance company within 60 days is the responsibility of the patient. Balances over 90 days will be forwarded to a collections agency and assessed an additional charge of 30% of the outstanding balance.

Please Note

- **Medley Smiles requires a deposit, or payment in full, to reserve treatment appointments.**.
- **Please give us at least 48 hours notice if you need to cancel or reschedule your appointment. A $50 fee will be charged per hour scheduled, if this consideration is not given.**
- **Checks returned for insufficient funds will result in an additional $30 charge**

If you have any questions, please don't hesitate to ask. We are here to help you get the dentistry you want and need.

Patient's name (print)____

Patient, parent or guardian signature________________________________Date_____________