

Winning Smiles Financial Policy

*Our office is committed to providing you with the highest quality dental care using only the best materials and technology available. Our clinical and business teams work closely together to provide a positive environment for visits to our office and assistance with financial requirements. **Payment for professional services is expected at the time dental treatment is provided.** A member of our Business Team will be delighted to discuss our options with you!*

We are happy to file dental claims for our families who have dental insurance. In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. Filing to your insurance carrier is not a guarantee of payment. Please understand that the patient or parent/guardian has the final responsibility for payment of any services rendered. Our doctors recommend treatment based on our patients' needs, not on what insurance will pay.

a. Payment options: For your convenience, we accept cash, personal checks, debit cards, Visa, MasterCard, Discover, Flexible Spending Accounts, Health Saving Accounts and CareCredit.

b. Financial responsibility: Self-pay patients are expected to pay for services received in full at the time of service. Any alternative financial arrangements must be made before you see the dentist. The parent or guardian bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

c. Divorce/separation: The party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce/separation, the parent or guardian bringing the child and authorizing treatment will be the person responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We will provide you additional copies of receipts if needed.

d. Required payments: At treatment

visits, we collect a percentage of the total cost of treatment, determined by ESTIMATION of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will receive a credit on your account, or you may request reimbursement by mailed check.

e. Authorization: If your insurance plan requires an authorization we will need to receive the authorization before you or your child sees the dentist. If we have not received the authorization prior to your appointment, we will need to reschedule the appointment until it is received.

f. Deposit: Certain procedures may require a deposit, including deductibles, co-payments and coinsurance. Payment of these amounts is required before the procedure is performed.

g. Uncovered services: In the event your insurance company determines a service to be "not covered," or reimburses Winning Smiles lower than the anticipated amount, you will be responsible for payment. We try to inform patients when services may not be covered; however, it

is the patient's responsibility to understand their dental insurance limitations. Most benefits will be verified before your insurance company can be billed. In the event that your insurance has not paid within 60 days, the balance may be transferred to your account.

h. Returned check fee: A \$35.00 service charge will be applied to your account for any returned check. If a check is returned, we will only accept cash or a credit card as payment on your account.

i. Canceling/rescheduling: Scheduled appointments that are missed, changed, or canceled with less than 48 hours of notice will be charged a fee of \$50 (hygiene appointments) or \$75 (treatment appointments).

j. Past due accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued. If your account becomes past due over 90 days, a collections process may be used to collect funds. All reasonable expenses incurred during the collection process will be the account holder's responsibility.

Effective date: Once you have signed this policy, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

I have read the above policies and understand my obligations with Winning Smiles for my or my child's dental care. I acknowledge that I am responsible for payment of any services not covered by my insurance plan.

Print name of person signing _____

Relation to patient: _____

Signature: _____

Date: _____

Patient Registration Form

Email: _____			Today's Date: _____		
Preferred Name: <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Referred by: _____		
Name: _____		Home Phone: <i>include area code</i> ()		Cell Phone: <i>include area code</i> ()	
Last First Middle					
Address: _____			City: _____		State: _____ Zip: _____
Mailing address					
SS#: _____		Date of Birth: _____		Sex: M F	
Employer: _____			Business Phone: <i>include area code</i> ()		
Emergency Contact: _____		Relationship: _____		Home Phone: <i>include area code</i> () Cell Phone: <i>include area code</i> ()	
College Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			Please provide school info: _____		School Name: _____
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired			Address: _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Address 2: _____		
Pref. Pharmacy: _____ Phone: ()			City, State, Zip: _____		

Dental Insurance Information

Primary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	
Secondary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time? _____			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays: _____			
What is the reason for your dental visit today? _____							
How do you feel about your smile? _____							

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK	Yes No DK
Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physician Name: _____ Phone: include area code (_____) _____ Address/City/State/Zip: _____	Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what was the illness or problem? _____
Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what condition was treated? _____	Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____
Date of last physical exam: _____	Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED
Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormone replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment Began: _____	

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?
Date: _____ If yes, have you had any complications? _____

Allergies - Are you allergic to, or have you had a reaction to: **Yes No DK**
To all **yes** responses, specify type of reaction.

Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbituates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever / seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Yes No DK	Yes No DK	Yes No DK	Yes No DK
Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Artificial heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____	Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Recurrent infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	G.E. Reflux/Persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type of infection: _____
Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Coronary artery disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe headaches/ Migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cancer/Chemotherapy/ Radiation treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
Name of physician or dentist making recommendation: _____ Phone: (_____) _____
Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
Signature of Patient/Legal Guardian: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices and Consent for Use and Disclosure of Information

* You May Refuse to Sign This Acknowledgement

Print Name: _____

Signature: _____

Date: _____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation. Revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat your child or to continue treating your child if you revoke this Consent.

Right to Object: You have the right to request that we restrict how your child's protected health information is used or disclosed for treatment, payment, or health care operations. We are not required to agree to these restrictions, but if we do agree we will be bound by the restrictions. We may decline to treat your child if such restrictions are placed on us. If you decline to sign this consent and acknowledgment, we may decline to treat your child.

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment and consent could not be obtained because:

Individual refused to sign

Parent did not accompany under age minor

Communications barrier prohibited obtaining the acknowledgment

An Emergency situation prevented us from obtaining acknowledgment

Other _____