Q Smiles Dental

www.qsmilesdentalpc.com
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Welcome!

Dental Registration and History

Please don't hesitate to ask if you have any questions

1. PATIENT INFORMATION

Patient Name _____
Last Name First Name Middle Initial

Date _____ Birthday _____

SS# or Insurance ID# _____ Sex ☐ M ☐ F

Address _____

City _____ State _____ Zip _____

Home Tel _____ Work Tel _____

Mobile # _____ Occupation _____

Email _____ Marital Status _____

Referral Source _____

Notes _____

2. EMPLOYER / SCHOOL

Employer/ School Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Notes _____

3. EMERGENCY CONTACT

Emergency Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Relationship _____

4. INSURANCE INFORMATION

Responsible Party Name _____

Relationship to Patient _____

Insurance Company _____

Subscriber Name _____

Group # _____ SS# _____

Birthday _____ Other Coverage ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with: _____

and assigned directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information in the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan to completed or one year from the date signed below.

Signature _____ Date _____

5. DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Tel _____ Last X-Ray Date _____

Last Cleaning _____ Last Dental Visit _____

Do you feel pain ☐ Yes ☐ No if yes please describe _____

Do you feel numbness, swelling, or any other sensitivity? ☐ Yes ☐ No if yes please explain _____

Additional comments about your past dental history _____

Please Continue to 2nd Page

Welcome!

Dental Registration and History Page 2

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6. HEALTH HISTORY

Physician Name _____ Physician Tel _____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentennine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type __	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
		Do you wear contact lenses?	☐ Yes ☐ No		

Women: Are you pregnant? ☐ Yes ☐ No If yes due date: _____ Are you nursing? ☐ Yes ☐ No

7. MEDICATION & ALLERGIES

Please list all the medication you are currently taking _____

_____

_____

_____

Please list any known allergies _____

_____

Are you allergic to any of the following? ☐ Yes ☐ No

If yes please circle: Aspirin, Barbiturates (Sleeping pills), Codeine, Iodine, Latex, Local Anesthetic, Penicillin

Any other allergies? ☐ Yes ☐ No

8. UPDATES (for future visits)

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Signature _____ Date _____

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Office Policies and Procedures

Self-pay patients and Co-payments (co-pays) are required the day of service

Phone Message
During business hours, any message left on our voicemail will be returned before we leave for the day. Message left for our staff after hours will be addressed on the next business day.

Appointment Cancellation
Please give at least 24 hours notice of cancellation by calling us at (571) 208-1325. This will allow time for another patient to be scheduled. Because we value the time spent with our patients, appointments that you make reserved solely for YOU and THE DOCTOR, and therefore **you will be subject to a $50 for any broken appointment**. Patients who "no show" for an appointment three or more times will no longer be allowed to schedule in advance for appointments. These patients may call to schedule an appointment, if available, only on the same day for which they are seeking treatment.

Billing
We will file your assigned insurance claims for you as an additional service. Please remember that your insurance policy is a contract between you and your insurance company. You may need to contact your insurance company to resolve payment disputes. Payment for services is your responsibility and will be expected from you if insurance denies payment for services. Our office will make every attempt to collect from your insurance company. In the rare event that your insurance company doesn't pay within 60 days, the patient will be responsible for the balance in full for any service provided by Q Smiles Dental.

Discounted Fee Schedules
Discounted plans such as Careignton dental plans which allow patients to receive dental services at discount rate. IN ACCORDANCE WITH YOUR CONTRACT, PAYMENT IN FULL IS REQUIRED AT THE TIME THAT SERVICES ARE RENDERED.

Financial Agreement
I acknowledge that all charges incurred in this office are my responsibility. Should my insurance, for any reason, fail to pay for all charges billed, I agree to pay for services upon notification by a representative of this office. I understand that if my account remains unpaid by me for a period of 90 days, it may be referred to an attorney for collections. I understand that if I fail to pay the balance owe to Q Smiles Dental within the given period there will be an interest of 1.5% applied to the total balance per month or 20% per annual. Unpaid balance after a year will be referred to an attorney and patients will be responsible for all cost incurred including collections fees and any legal fees for collection services and attorney's fee.

Type of Payment Accepted
Q Smiles Dental accepts cash, checks **($40 fee for all returned checks)** and most major credit cards.

Duplication of Records
In the event that your records need to be transferred for any reason other than a referral from our office, there will be a charge of $50 per set of x-rays to be transferred. We are required by law to keep your records on file for a period of 7 years. For patients that have received discounted rates for x-rays (i.e. $57 new patient special or Q Plan) the full price of $100 will be charged for x-rays, in addition to $50 duplication fee, prior to transferring of x-rays.

Patient Updates
Please be sure to keep us updated of any address, phone, and/or insurance changes so that we can keep our records current and communicate your health status with you.

Date: _____ Name: _____ Signature: _____