PATIENT INFORMATION

Date: _____

Name: _____

Address: _____

_____

Phone: _____ Text Messages? YES NO

Email: _____

Sex: M F Birthdate: _____

SSN # _____

Please tell us how did you hear about us?

_____

SPOUSAL/PARENT/GUARDIAN INFORMATION

Name: _____

Birthdate: _____ SSN # _____

Phone: _____

Employer: _____

EMPLOYER INFORMATION

Occupation: _____

Employer: _____

Employer Phone: _____

EMERGENCY CONTACT

Name: _____

Phone: _____

Relationship: _____

INSURANCE INFORMATION

Subscriber: _____

Birthdate: _____

Relationship to Patient: _____

Insurance Name: _____

Insurance Phone: _____

ID Number: _____

ASSIGNEMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have ( ) Have not ( ) insurance coverage and assign directly to **PEARL SMILE, PLLC** all insurance benefits. If any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether not paid by insurance. I authorized the use of this signature on all insurance submissions.

I hereby authorize the release of medical information to any of my health care providers or insurance companies that may be pertinent to my case. I hereby authorize direct payment of insurance benefits that are otherwise payable to me. I hereby authorize the release of my medical records to third-party insurers or other persons to whom disclosure is necessary to establish or collect a fee for services provided. I understand that payment in full or any co-pays related to my insurance is due at the time services are rendered, however, I agree to pay a finance charge of 1.5% per balances over thirty (30) days past due, which is an annual percentage rate of 18%. If my account is referred to an attorney or to a collection agency for collection, I agree to pay all collections fees and court costs, including attorney's fees or collection agency feels in the amount of thirty-three and one-third percent (33.3) of the total indebtedness then due. A photocopy of the contract shall be considered as valid as the original. This contract is binding for current and future transactions.

Our office requires 24-hour notice for canceling or rescheduling appointments. If at least 24-hour notice is not given, a broken appointment fee of $35 will be charged to the patient. Office policy also dictates that if a patient is more than 15 minutes late for their appointment it will be rescheduled, and a broken appointment fee will be incurred.

Printed Name: _____

Signature: _____

Date: _____

Appointments and Cancellations

Pearl Smile PLLC
8600 Quioccasin Rd
Suite 205
Henrico, VA 23229

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit (Except for emergency treatment and visits). You can expect us to be prompt and we, of course appreciate the same courtesy from you.

When we make your appointment, we are reserving a room for your needs. We ask that if you must change an appointment, please give us at least 24 hours' notice or let us know if you are going to be late. This courtesy makes it possible to give your reserved room to another patient who would like it and our schedule to flow as easy as possible.

There is a charge of $35 for not showing up for scheduled appointments.

Repeated cancellations or missed appointments will result in loss of future appointment privileges and/or the dismissal from our office.

We send courtesy reminders through text or phone calls. However, you are solely responsible for maintaining your schedule time.

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

Patient Name: _____

Responsible Party's: _____

Signature: _____ Date: _____

PEARL SMILE DEFAULT 2020

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

Do you have any Dental Issues?	◯ Yes ◯ No	If yes
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you had an Artificial knee or hip replacement?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you taking blood thiners medications?	◯ Yes ◯ No	If yes
Do you have Osteoporosis?	◯ Yes ◯ No	
Do you snore?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

What is your Pharmacy Name, Location and Telephone number?	☐	If yes

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other Allergies?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

Pregnant/Trying to get Pregnant?	◯ Yes ◯ No
Nursing?	◯ Yes ◯ No

If Pregnant, Do you know your due date?	◯ Yes ◯ No	If yes
Do you know your OBGYN's name and telephone?	◯ Yes ◯ No	If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No
Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No				

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

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:_____

PEARL SMILE, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND DISCLOSURE OF PATIENT INFORMATION

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please print Name

_____

Signature Date

Signing of this document will allow us to share your information with your insurance company, referred specialist and health professionals. Are there additional people you would like us to share your information with? YES NO

Name	Relationship
Name	Relationship
Name	Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An Emergency prevented us from obtaining acknowledgement
- ❑ Other (please specify: _____)

Financial Policy

Pearl Smile PLLC
8600 Quioccasin Rd
Suite 205
Henrico, VA 23229

This is an agreement between Pearl Smile PLLC as creditor and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Pearl Smile PLLC.

By executing this agreement, you are agreeing to pay for all services that are received.

Services: Payment options if you have no insurance:

1. You choose to pay by ____cash or ____credit/debit card on the day that treatment is rendered.
2. We offer special financing through Care Credit.
   PERSONAL CHECKS NOT ACCEPTED

Services with Insurance: All presented treatment will be submitted to your insurance. We will do our best to let you know if any charges are due, but responsibility may be deferred to you after the insurance reviews the claimed treatment thus making you responsible of any payments. All copays and coinsurance will be charged at our best estimation.

Broken Appointments: Unless appointments are cancelled **at least 24 hours** in advance there will be a broken appointment fee of $35.00 placed on your account and you will be responsible for this fee.

Please help us serve you better by keeping your scheduled appointments.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will be your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. We will provide an estimate of the responsibility of your cost. You must agree to pay any portion of the charges not covered by insurance.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. You understand that you will be responsible for all collection costs, attorney fees and court costs that will occur in any legal action.

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

Responsible Signature _____ Date _____

Patient's Name: _____ Relationship: _____