Zenith Family Dental

We are pleased to welcome you to our practice. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient Name:_____ Prefers to be called by:_____

Sex: Male Female Status: Married Single Child Other _____ Date of Birth: _____

Address: _____

Phone (H): _____ (C): _____ (W): _____ Ext: _____

Social Security #: _____ E-mail Address: _____

In case of emergency, contact: _____ Phone: _____ Relationship: _____

Responsible Party Information (If Other Than Patient)

Name:_____ Relationship to Patient: _____
Sex: Male Female Status: Married Single Child Other _____ Date of Birth: _____

Address: _____

Phone (H): _____ (W): _____ Ext: _____ Best Time to Call: _____

Social Security #: _____ E-mail Address: _____

Insurance Information

Primary Insurance Information:_____ ID # / SS #:_____

Name of Insured: _____ Date of Birth: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____ Employer Name:_____ Group#: _____

Secondary Insurance Information:_____ ID # / SS #:_____

Name of Insured: _____ Date of Birth: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____ Employer Name: _____ Group#: _____

Medical Insurance Information:_____ ID # / SS #:_____

Name of Insured: _____ Date of Birth: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

_____

Signature of Patient/ Legal Guardian **Patient/Legal Guardian Name Printed** **Date**

Zenith Family Dental

Whom may we thank for referring you to our practice? Name of person or office referring you to our practice:

_____

Dental HIstory

Patient Name _____

Reason for Today's Visit: _____

Former Dentist: _____ Address: _____

Date of last dental care: _____ Date of last dental x-rays: _____

Have you ever had a bad dental experience? If yes explain:_____

Check (✓) if you have had problems with any of the following

Bad breath	Grinding teeth	Sensitivity to sweets
Bleeding gums	Loose teeth or broken fillings	Do you snore
Clicking or popping jaw	Sensitivity when biting	Do you have Sleep Apnea
Food collection between teeth	Sensitivity to hot or cold	Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____ Are you happy with your smile? _____

Medical History

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? Yes No If yes, describe: _____ Have you ever had a blood transfusion? Yes No If yes, give approximate dates: _____ **(Women)**

Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

AIDS	Circulatory Problems	Hepatitis	Rheumatic Fever
Anemia	Cortisone Treatments	High Blood Pressure	Scarlet Fever
Arthritis, Rheumatism	Cough, Persistent	HIV Positive	Shortness of Breath
Artificial Heart Valves	Cough up Blood	Jaw Pain	Skin Rash
Artificial Joints	Diabetes	Kidney Disease	Stroke
Asthma	Epilepsy	Liver Disease	Swelling of Feet / Ankles
Back Problems	Fainting	Mitral Valve Prolapse	Thyroid Problems
Blood Disease	Glaucoma	Nervous Problems	Tobacco Habit
Cancer	Headaches	Pacemaker	Tonsillitis
Chemical Dependency	Heart Murmur	Psychiatric Care	Tuberculosis
Chemotherapy	Chemical Sensitivity	Radiation Treatment	Ulcer
Cholesterol (High)	Hemophilia	Respiratory Disease	Venereal Disease

OTHER PROBLEMS NOT LISTED ABOVE: _____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

Have you ever taken any Bisphosphonate Bone Supplements? If so, for how long? (ex. Fosamax, Zometa, Aredia, Didronel, Actonel, Skelid, Boniva) _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes.

_____

Signature of Patient/ Legal Guardian **Patient/Legal Guardian Name Printed** **Date**

Zenith Family Dental

Insurance Information

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense. **Insurance is a method of payment not a method of treatment.** Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

It often takes us a considerable amount of time to try to collect your insurance payment for you. We often need your help to discuss your situation directly with your insurance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, we cannot render services on the assumption that our charges will be paid by an insurance company. In addition, this form also authorizes this practice to submit insurance claim forms and receive payments directly from the Insurance carrier with the notation "SIGNATURE ON FILE".

Insurance co-payments and deductibles are due at the time of service. If an account is outstanding for more than sixty (60) days, a monthly service charge of 1.5% may be added to the balance. If the account is not cleared within the time specified, the account will be turned over to our collection service with an additional charge of 25% towards the pending balance and a report may be filed with a credit servicing agency. I agree that Zenith Family Dental and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature of Patient/Legal Guardian _____ **Date**_____

Your time is valuable to us. Therefore, we make every effort to see you at your reserved time. As a client, you are responsible to maintain your scheduled time. In the event that you need to cancel or modify your appointment, we ask that you do so at least 24 hours prior to your scheduled time. Failure to do so will result in a missed fee charge of $50 per half hour. We thank you for your cooperation in assisting us to better serve our clients in an efficient manner.

Zenith Family Dental

Extensive Treatment Scheduling

A 10% deposit is required for all restorative procedures. A $150 deposit is required for all procedures reserved for more than 90 minutes. This amount will be applied to your out-of-pocket expenses not covered by your insurance. Should you miss your appointment without cancellation 24 business hours before; your deposit will be forfeited.

Privilege of a Saturday Appointment

At Zenith Family Dental, we understand how difficult it can be for patients and their families to find time for scheduling dental appointments. After school activities, sports teams, work, family and social obligations all require time from packed schedules. Our flexible scheduling is part of our dedication to serving our patients and their families. We want you to get the best dental care you need, when you need it. We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 24 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Failure to give 24 business hour advance notice:

- No privilege of a Saturday appointment for future appointments, until 3 consecutive completed weekday appointments

Definition of "Broken Appointment": A broken appointment is when you

- Cancel or reschedule an appointment with less than 24 hour notice
- Do not show up for the scheduled appointment

Consent

Yes____/No____ I hereby authorize and direct the dentists of Charming Smiles Family Dentistry and/or dental auxiliaries of their choice, to perform treatment that is necessary or recommended.

Yes___/No___ _I authorize my Dentist(s) to release treatment records/ x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.

Yes___/No___ I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or treatment.

I acknowledge that the practice may send the following electronic communications:

Yes____/ No_____ Information about my invoice or accounts payable upon request, to patient/legal guardian

Yes_____/No_____ Information about a specific dental visit

Yes_____/No_____Digital x-rays, referrals and/or orders to a dental specialist about treatment

I have read and understand the above and acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices". I have reviewed, understand, and agree to comply with the above office policies.

Signature of Patient or Legal Guardian **Patient/Legal Guardian Name Printed** **Date**

X-Ray Consent/Periodontal Scaling Consent

I understand that I am having the following treatment and acknowledge the important information below:

Dental X-Rays:

I understand that it is necessary to take x-rays for dental diagnosis as recommended by my treating Dentist. Though dental x-rays exposure is minimal, every effort to reduce my exposure has been taken with the use of a lead apron and thyroid collar (double shield for pregnant patients). I understand that cumulative exposure to x-ray is potentially harmful. If I am pregnant or may be pregnant, I have advised my Dentist and any members of her staff involved in x-ray procedures. X-rays will be taken as the dentist deems medically necessary and by initialing and/or signing this statement, I give my treating Dentist and appropriate staff my understanding of the risks and benefits of taking dental x-rays while I am a patient in their office.

Initial:_____ Date:_____

Dental Scaling: (Also known as: gross debridement, deep scaling, deep cleaning). These procedures are to clean and/or aid in rehabilitation of the gums, teeth and underlying bony structures. Periodontal disease is often chronic and asymptomatic. Upon completion of, or during these procedures, I may have sensitive gums or teeth, especially around the interface between the teeth and gums. Often, gumline sensitivity is noticed for a few hours to several days after these procedures. Occasionally, soft tissue or gum swelling may occur. Should any of these conditions arise and not subside within a few days of these procedures, I will contact my treating Dentist for advice and potential follow-up treatment. Sometimes these procedures uncover dental conditions, which were not readily apparent at an initial exam. These procedures are often part of the diagnostic procedures to determine dental conditions I may have. These procedures will be prescribed as the Dentist deems necessary and by initialing and/or signing this statement, I give my treating Dentist and appropriate staff my understanding of the risks and benefits while I am a patient in their office.

Initial:_____ Date:_____

ZENITH FAMILY DENTAL NO SHOW/CANCELLATION POLICY

Thank you for entrusting your dental care to Zenith Family Dental. We strive to provide you with world class care in a relaxing, friendly, and efficient environment. To achieve these objectives, we must develop a cooperative and comprehensive cancellation and no show policy. We believe that this policy will assist us in streamlining the appointment process and provide greater coordination of patient flow within our office.

One of the foundations of the policy is an appointment reminder system. This system sends reminders at strategic time intervals before each appointment.

We therefore require each patient to provide us with a required response to the reminders either to confirm or cancel their appointment. If you do not respond to the reminders, your appointment may be assigned to a patient on our waiting list. If you need to cancel your appointment please provide a minimum of 24hrs' notice for a **general exam, cleaning and 48 hrs for any dental procedures other than a new patient or routine cleaning/exam.**

Our cancellation policy requires 24hrs notice or a fee of $50 will be charged. All appointments scheduled for Monday should be canceled by 3pm the previous Friday. Appointments canceled on Saturdays and Sundays, or Public Holidays do not meet the 24hrs notice requirement and will be charged the cancellation fee. If you are a "no show" for any appointment, you will be charged $50 for the first occurrence and $100 for each occurrence thereafter.

If you have an appointment scheduled on a Saturday, and you cancel less than 24hrs for a general cleaning/exam (48 hrs for dental procedures other than a cleaning/exam), or are a "no show" a fee of $50 will be charged. In addition you

will not be able to reschedule for another Saturday, you will be required to be seen during the week before scheduling another Saturday appointment.

If you are unable to make your appointment, it is important that you call us at 301 235-9944, or email us at zenithfamilydental@gmail.com as soon as possible so that we can update our schedule. By signing this document you are agreeing to the full content of the document.

Signature of Responsible party **Date**