Welcome to our Practice

PATIENT INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐	First Name:		M.I.	Last name:		Nickname:	
Sex M ☐ F ☐	Birth Date:	Age	SSN #		**E-mail:**		
Street:			Apt #	City:	State	Zip	
Home ( )	Cell ( )		I consent to text messages being sent to my cellphone			Yes ☐	No ☐
Work ( )	Other ( )		I consent to voicemail being left on answering machine			Yes ☐	No ☐
Driver's Lic #	Employer:		I Consent to a message being left with a family member / Representative			Yes ☐	No ☐
Emergency contact:			I Consent to emails being sent to my email account			Yes ☐	No ☐
Tel ( )	Relation:		**Whom may we thank for referring you to QN Smiles?**				

RESPONSIBLE PARTY INFORMATION

☐ Self (*if self, skip this section*)	☐ Spouse	☐ Father	☐ Mother	☐ Other_____	
Mr. ☐ Mrs. ☐ Ms. ☐	First Name:	M.I.	Last name:	Driver's Lic #	
Sex M ☐ F ☐	Birth Date:	Age	Soc. Sec. #	**E-mail**	
Street:		Apt:	City	State	Zip
Home ( )	Cell ( )	Have you ever been a patient of our practice?		Yes ☐	No ☐
Work ( )	Other ( )	Employer:			

DENTAL INSURANCE INFORMATION

☐ No insurance (*if no insurance, skip this section*)

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Co. name:		Insurance Co. name:	
Subscriber's Name:		Subscriber's Name:	
Subscriber's date of birth:		Subscriber's date of birth:	
Member ID number or SSN:		Member ID number or SSN:	
Group number:		Group number:	
Employer:		Employer:	

Assignment and release
This signature on file is my authorization for the release of information necessary to process all insurance submissions. I hereby authorized payments to QN Smiles of the benefits otherwise payable to me.

✖ _____ ✖ _____
Signature of patient (*parent or guardian if minor*) **Date**

Assignment and release
This signature on file is my authorization for the release of information necessary to process all insurance submissions. I hereby authorized payments to QN Smiles of the benefits otherwise payable to me.

✖ _____ ✖ _____
Signature of patient (*parent or guardian if minor*) **Date**

DENTAL INFORMATION

Reason for today's visit:		Are you in pain Yes ☐ No ☐	For how long?
Please indicate any of the following problems by checking off the corresponding box:			
☐ Discomfort, clicking, or popping in jaw	☐ Problems associated with previous dental treatment	☐ Prolonged bleeding from an injury / extraction	☐ Swelling / lumps in mouth
☐ Red, swollen, or bleeding gums	☐ Teeth grinding / clenching	☐ Bad breath	☐ Loose / shifting teeth
☐ A removable dental appliance	☐ Broken / chipped tooth	☐ Burning tongue / lips	☐ Food caught between teeth
☐ Blisters / sores in or around the mouth	☐ Recent infections or sore throat	☐ Toothache	☐ Stained teeth
☐ My teeth are sensitive to: Hot ☐ Cold ☐ Sweets ☐ Biting ☐	Other: _____ _____		
Are you happy with your smile? Yes ☐ No ☐	Last dental exam:	Times a day you brush?	Times a week you floss?

MEDICAL HISTORY

Are you being treated by a physician now? Yes ☐ No ☐	If yes, please explain:
Has your physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐	
Name of the physician or dentist making recommendation:	Phone ( )

Do you have, or have you had, any of the following diseases, medical conditions, or procedures? *check off the corresponding box:*

☐ Heart disease	☐ Prolonged bleeding or Hemophilia	☐ Herpes (mouth / cold sores)	☐ Sexually transmitted / venereal disease
☐ High blood pressure	☐ Tuberculosis / lung disease	☐ Kidney disease	☐ AIDS
☐ Anemia	☐ Asthma	☐ Chemo / Cancer / Leukemia	☐ Mononucleosis
☐ Stroke	☐ Hay fever	☐ Radiation therapy	**Women**
☐ Heart attack When? _____	☐ Sinus trouble	☐ Immune suppressed / disorders	☐ Pregnant (check if unsure) weeks: _____
	☐ Epilepsy / Seizures	☐ Fainting / dizziness	
☐ Chest pain	☐ Ulcers, stomach problems	☐ Glaucoma, eye disease	☐ Nursing
☐ Cardiac pacemaker	☐ Implant / Artificial joints when? _____	☐ Nervousness / emotional / depression	☐ Taking birth control
☐ Congenital heart lesions		☐ Thyroid problem	**Men**
☐ Diabetes Type: _____	☐ Arthritis / Rheumatism	☐ Liver disease / Hepatitis Type: ____	☐ Taking ED Meds.

MEDICATIONS & ALLERGIES

Are you using any of the following? *check off the corresponding box:*			☐ Thyroid meds
☐ Antibiotics	☐ Pain medication	☐ Recreational drugs	☐ Sedative-hypnotic agents
☐ Anticoagulants (blood thinners)	☐ Aspirin or Ibuprofen	☐ Steroids	☐ High blood pressure medications
☐ Heart drugs	☐ Insulin or oral anti-diabetic drugs	☐ Antianxiety or antidepressants	☐ Bone density meds

List any other medication that you are currently taking (including natural, herbal, or homeopathic products)

Pharmacy:	Phone ( )

Are you allergic to or have any you had an adverse reaction to:

☐ Local anesthetics / Novocain	☐ Codeine / Narcotics	☐ Barbiturates (sleeping pills)	☐ Other drug allergies: _____ _____
☐ Aspirin, Motrin, Aleve, or Iboprufen	☐ Latex / plastic	☐ Sulfa drugs	
	☐ Penicillin or other antibiotics	☐ Food products	

I certify that I Have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

RELEASE OF INFORMATION/DISCLOSURE OF OWNERSHIP

In general, medical information concerning the patient's procedure is treated as confidential by QN Smile and its personnel. QN Smile may lawfully release such information to others without your written consent. QN Smile is permitted, without your written consent, to release such medical information to your healthcare insurance company or other legal entity providing healthcare coverage to the extent necessary in order to determine that entity's liability for payment.

I have been informed prior to the date of service that the Dentist(s) who perform procedures at QN Smiles may have an ownership interest.

HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been given an opportunity to read and review the HIPAA privacy practices of QN Smile, PLLC.

I certify that I have read the foregoing and that I am either the patient, parent, guardian or duly authorized by the patient's general agent to execute the above and accept its terms.

I authorize QN Smiles to discuss/release my confidential health information to the following family member/friend/POA listed below:

Name: _____ Phone Number: _____ Address: _____

Name: _____ Phone Number: _____ Address: _____

✖_____ _____ _____ ✖_____ _____

Signature of patient / Responsible party **Relationship** **Date** **Witness (Staff)** **Date**

FINANCIAL POLICY

During your first visit we will discuss the number of visits needed for your treatment, the length of each visit, and the projected costs involved. We deliver the finest care at the most reasonable cost to our patients; therefore, **payment is due at the time service is rendered unless other arrangements had been made in advance**.

Please note that you are fully responsible for all fees charged by our office regardless of your insurance coverage.

Fees: Fees will vary greatly depending on the type of treatment needed. Fees are based on the tooth involved, the type of treatment necessary, and the extent of the treatment provided. During your consultation, we will discuss the necessary number of visits, their lengths, and the fees involved.

Patients with Dental Insurance: We will assist you to the best of our ability in obtaining the maximum benefits from your insurance and as a courtesy to you, our office will gladly submit dental claims to your insurance company. Our office does participate with a variety of Dental PPO, Texas MEDICAID and CHIP, Fee for Service Plans, Traditional Plans, Indemnity Plans and Discount Program Plans. Please check your type of plan carefully and for more specific information about benefit amounts, please call your insurance company.

Payment Options: We accept cash, check, VISA, MasterCard, American Express, Discover and Care Credit. A charge of $30 will be applied for returned checks. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected but never higher that our office's UCR (Usual, Customary, and Reasonable) Fee or our contractual obligation with your insurance company whenever apply. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due on the statement receive date.

Unpaid Insurance Claims: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past-Due Accounts: All delinquent accounts at QN Smiles accrue interest at the legal rate. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account and will also become the financial responsibility of the account holder.

Financial agreements: financing for balances over $200 are available for qualifying patients. A credit card authorization is required for approval. For balances under $600 we offered a 3 months monthly payment plan with 0% APR and for balance over $600 we offered a 6 months payment plan with 0% APR, for other deferred interest options we accept Care Credit. Financial agreement for Orthodontic treatments is separated from dental treatment.

QN Smiles, PLLC reserves the right to update and make changes the above-stated office policies at any time without prior notification.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

✖_____ _____ ✖_____

Signature of patient / Responsible party **Relationship** **Date**

Rev: 06/14/2018

CANCELLATION AND NO-SHOW POLICY

Your time is very important to us; therefore, this office makes every effort to stay on schedule. We make certain that ample time is provided for each patient; for both office visit appointments and all of our dental procedures that are done as part of a treatment plan.

We do not overbook patients; we allow each patient the quality time and consideration necessary for their specific dental needs. We do, however, see patients with highly complex problems that often require additional time.

As you may relate to, we often have many patients requiring care who are waiting to be seen by our providers. If a patient does not provide timely notice that they will not be able to make their scheduled appointment, we will not have time to schedule another patient that, in some cases, desperately need to be seen.

For this reason, we kindly request at least 24 hours' notice prior to cancelling or rescheduling an office visit appointment and 48 hours' notice for treatment procedures.

Please note that **we reserve the right to charge your account:**

- **$25 for missed appointment.**
- **$25 for late cancellation.**

We value your time and expect the same courtesy in return. additionally, **the office reserves the right to revoke appointment privileges for non-compliance patients.** We understand that unforeseen event might happen and a late cancelation not always can be avoided and therefore we will give a first warning before enforcing this clause.

So, please notify our office in advance during regular business hours if you need to cancel or reschedule your appointment according to the timeframes listed above.

QN Smiles reserves the right to update and make changes to the above-stated office policies at any time without prior notification.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for me and my dependents accounts (if applicable).

Thank you for your understanding and cooperation.

✖_____ _____ ✖_____

Signature of patient / Responsible party **Relationship** **Date**
Date

Rev: 08/20/2020