Patient Information

Last Name _____ First Name _____ Middle Initial _____ Date _____

Address:_____ City:_____

State:_____ Zip:_____ Male / Female Married / Single / Divorced / Widowed

Social Security #_____ Birth Date:_____

Phone Number-Home:_____ Cell:_____

Employer:_____ Work Phone:_____

Student Status: Part Time / Full Time Email Address:_____

(Please provide a copy of your student I.D. card)

Responsible Party Information (if minor, this would be the person signing treatment forms)

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____ Social Security # _____

Address:_____City:_____State:_____Zip:_____

Phone Number-Home:_____Work:_____ Cell:_____

Medical History

Are you under a physician's care now?	*Y / N*	*If yes, please explain*_____
Have you been hospitalized or had a major operation?	*Y / N*	*If yes, please explain*_____
Have you ever had a serious head or neck injury?	*Y / N*	*If yes, please explain*_____
Are you taking any medications, pills, or drugs?	*Y / N*	*If yes, please explain*_____
Are you on a special diet?	*Y / N*	_____
Do you use tobacco?	*Y / N*	_____
Do you use controlled substances?	*Y / N*	_____
Are you pregnant or trying to get pregnant?	*Y / N*	_____

Do you have or have you ever had any of the following? (circle Yes or No)

Aids/HIV	*Y / N*	*Chest pain*	*Y / N*	*Frequent Headaches*	*Y / N*	*Liver Disease*	*Y / N*
Anaphylaxis	*Y / N*	*Cold Sores/Fever Blisters*	*Y / N*	*Hay Fever*	*Y / N*	*Mitral Valve Prolapse*	*Y / N*
Anemia	*Y / N*	*Congenital Heart Disease*	*Y / N*	*Heart Attack/Failure*	*Y / N*	*Pain in Jaw/Joints*	*Y / N*
Angina	*Y / N*	*Convulsions*	*Y / N*	*Heart Murmur*	*Y / N*	*Psychiatric Care*	*Y / N*
Arthritis / Gout	*Y / N*	*Cortisone Medications*	*Y / N*	*Heart/Pace Maker*	*Y / N*	*Radiation Treatment*	*Y / N*
Artificial Heart Valve	*Y / N*	*Diabetes*	*Y / N*	*Heart Trouble/Disease*	*Y / N*	*Renal Dialysis*	*Y / N*
Artificial Joint	*Y / N*	*Drug Addiction*	*Y / N*	*Hemophilia*	*Y / N*	*Rheumatic Fever*	*Y / N*
Asthma	*Y / N*	*Easily Winded*	*Y / N*	*Hepatitis A*	*Y / N*	*Scarlet Fever*	*Y / N*
Blood Disease	*Y / N*	*Emphysema*	*Y / N*	*Hepatitis B or C*	*Y / N*	*Shingles*	*Y / N*
Blood Transfusion	*Y / N*	*Epilepsy/Seizures*	*Y / N*	*High Blood Pressure*	*Y / N*	*Sinus Trouble*	*Y / N*
Breathing Problems	*Y / N*	*Excessive Bleeding*	*Y / N*	*Hives/Rash*	*Y / N*	*Sickle Cell Disease*	*Y / N*
Bruise Easily	*Y / N*	*Excessive Thirst*	*Y / N*	*Hypoglycemia*	*Y / N*	*Stroke*	*Y / N*
C-Pap Machine	*Y / N*	*Fainting Spells/Dizziness*	*Y / N*	*Kidney Problems*	*Y / N*	*Thyroid Disease*	*Y / N*
Cancer	*Y / N*					*Tuberculosis*	*Y / N*
						Ulcers	*Y / N*

*Have you ever had any serious illness not listed above? Y / N If Yes, please explain:*_____

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Local Anesthetics Latex Other If yes, please explain_____

*Please list any current OTC and Prescription medications that you are taking.*_____

_____

Primary Insurance Information

_____Relationship to Insured: Self / Spouse / Child / Other
Last Name First Name Middle Initial

Insured I.D. #:_____Insured D.O.B._____SS#_____

Employer:_____ InsuranceCompany:_____

Address:_____ Address:_____

City:_____ City:_____

State:_____ Zip:_____ State:_____ Zip:_____

Phone:_____ Phone:_____

Secondary Insurance Information

_____Relationship to Insured: Self / Spouse / Child / Other
Last Name First Name Middle Initial

Insured I.D. #:_____Insured D.O.B._____SS#_____

Employer:_____ InsuranceCompany:_____

Address:_____ Address:_____

City:_____ City:_____

State:_____ Zip:_____ State:_____ Zip:_____

Phone:_____ Phone:_____

Whom may we thank for referring you to our office?_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in your care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is financially responsible for payment of all dental services. This office will help prepare your insurance forms or assist in making collections from insurance companies and will credit any such collections to your account. However this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1and 1/2 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration of the professional services rendered to me , or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within 5 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay the costs and reasonable attorney fees if suit be instituted hereunder. 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. I understand that in the event my account is sent to collections all future appointments will be cancelled and no further treatment will be extended until my account has been paid in full.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to patient:_____
Signature of patient, parent or guardian

_____ Date:_____ Relationship to patient:_____
Signature of guarantor of payment / responsible party

Shoals Smile By Design, PC

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. We agree in writing with every patient we see as to our financial policy, as we have found with experience that this makes our mutual experience easier, and ensures that all of our patients receive a high quality of dental care in a friendly and healthy environment with little time or financial difficulty. ***This policy as well as other health and insurance forms provided must be read, agreed to, and signed prior to any dental treatment.***

Cash Patients

Patients with no insurance are expected to pay cash, check or credit / debit card the day the service is rendered, unless specific arrangements are made in advance.

Insurance Patients

For those covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% of the cost of your treatment. In this day and age, many cover 50% or less on many services and actually cover nothing on others. Because of this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day service is rendered. ***We will estimate, as closely as possible, your coverage and co-payment, but until we actually receive the payment from the insurance company, it is just an estimate.*** **Some patients request that we send in a pre-determination to their insurance carriers for large treatment plans. We state what treatment you need and they tell us what they will cover on that treatment plan. Many patients prefer to get treatment started immediately, and some treatments *should* be started immediately. In cases where coverage is questionable, we will ask you to pay for your services in full as they are done, and when the insurance company pays their portion, we will reimburse you what they pay.** ***We will assist you in dealing with the insurance company but ultimately the responsibility of payment and any insurance problems lie with you.*** **If we do accept assignment of benefits from the insurance company and if the insurance hasn't paid after 45 days, the full balance is expected from you personally.**

Sometimes an insurance company will determine that they will pay only a partial payment for treatment rendered after the fact. Our experience has shown us that they do this sometimes for arbitrary reasons, or sometimes for no logical reason at all. Therefore, we have made it our policy that when you commit to treatment, you also commit to being responsible for paying for it, no matter what the insurance company claims or states about the treatment.

The above policies apply equally to parents and guardians of minors being treated and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility.

The undersigned also must understand that in the event of non-payment or default, they will be responsible for all costs of collection including, but not limited to, collection agency fees, reasonable attorney fees, court costs, and filing fees. 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. I understand that in the event my account is sent to collections all future appointments will be cancelled and no further treatment will be extended until my account has been paid in full.

Sincerely,
Dr Jamine C. Rogers

Signed:_____ **Date:**_____
(signature of patient or responsible party)

Shoals Smile By Design, PC

Jamine C. Rogers, DMD
301 W. State Street
Muscle Shoals, AL 35661
(256) 314-0676

Effective Date: July 1, 2006 Amendment: August 2014

To all of our patients:

Because of the recent high number of failed appointments and short notice cancellations, we have been forced to look into our office policy concerning this issue. In an effort to hold down the ever rising costs of operation to you, we have adopted the following policies effective July 1, 2006.

1. *We require 48 business* ***hours*** *notification if you plan to cancel your scheduled appointment or it will be considered a failed appointment.* **Each failed appointment will require an explanation as to the nature of failure.** *Forgetting* **is not an acceptable reason for a no show appointment, as we do all we can, within our power, to contact you at all listed phone numbers, about your appointment 48 hours in advance.** *If we leave a message prior, we request that you give us the courtesy of returning our call to either confirm or cancel the appointment.* **Any unconfirmed appointment will be given away on an as needed basis. If we are not able to get a confirmation from you your appointment will be cancelled.**
2. *On the 2nd failed appointment, we will issue a $25.00 broken appointment fee, per appointment, to your account.* **Example: 2 children from the same family would incur a $25.00 charge each. This fee will have to be paid prior to scheduling another appointment.**
3. *A 3rd failed appointment will result in immediate dismissal from this practice as a patient.*
4. **We can only allow scheduling of up to 2 persons from the same family on any given day, as the schedule permits.**
5. **Due to very limited space in our waiting area, please arrange for a babysitter for children and limit of one person to accompany a patient.**

We love and appreciate you for selecting us to provide the best dental care possible for you and your family. By following these rules your costs and waiting time can be kept to a minimum. Thank you for your help in these matters.

Dr Jamine C. Rogers and Staff

I have read and understand the letter above._____

Signature

_____

Date

Shoals Smile By Design, PC

Jamine C. Rogers, DMD
301 W. State Street
Muscle Shoals, AL 35661
(256) 314-0676

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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)

For Office Use Only

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

- o *Individual refused to sign*
- o *Communication barriers prohibited obtaining the acknowledgement*
- o *An emergency situation prevented us from obtaining acknowledgement*
- o *Other (Please Specify)*

Late Afternoon Appointments

There are not enough late afternoon appointments available in any given year to accommodate everyone with after work and school appointments.

Our appointments for late afternoon and early morning are offered on a first come basis, no showing, short notice cancelling, (less than **48 business hours** notice) will make it unlikely that you will receive another appointment in this time frame. Instead, you will be given our next available time.

All employers, schools and coaches realize that we have healthcare needs that must be met and we will provide you with a work/school excuse upon request.

Certain procedures are offered at specific times and or days; this allows us adequate time to perform more complex treatment.

As patient's ourselves at healthcare providers' offices we are aware of work/school schedule demands and while we would like to accommodate all late afternoon appointments this simply is not possible.

In order to provide you with quality care you will need to be flexible in your scheduling requests because we cannot see every patient after school and work.

Thank you for your cooperation.

Yours in Dental Health
Shoals Smile by Design