OFFICE
PATIENT
D.O.B.
INS COMP

DATE/TIME

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New Patient Information

(1) **PATIENT'S LAST NAME:**_____ **FIRST NAME:**_____ **M.I.:**____

(2) PATIENT'S DATE OF BIRTH(MM/DD/YYYY):_____ (3) GENDER: ☐ MALE ☐ FEMALE (4) SS #:_____

(5) PRIMARY CONTACT#: _____ ☐ CELL ☐ HOME ☐ WORK

(6) PURPOSE OF VISIT: ☐ EMERGENCY ☐ ROUTINE CHECK-UP ☐ OTHER:_____

(7) HOW DID YOU HEAR ABOUT US?:_____

INSURANCE & POLICY HOLDER'S INFORMATION

(8) Patient is same as policy holder? ☐ YES ☐ NO (If yes, then go to Question 10)

	PRIMARY INSURANCE	SECONDARY INSURANCE
(9) Policy holder's detail (If patient is not a policy holder)	a. Last.:_____ First: _____ M.:___ b. D.O.B.:_____ c. S.S.#: _____ d. GENDER: ☐ MALE ☐ FEMALE e. RELATION: ☐ SPOUSE ☐ CHILD ☐ PARENT OTHER:_____	a. Last:_____ First:_____ M.:___ b. D.O.B.: _____ c. S.S.#: _____ d. GENDER: ☐ MALE ☐ FEMALE e. RELATION: ☐ SPOUSE ☐ CHILD ☐ PARENT OTHER:_____
(10) Type of insurance	☐ PPO ☐ HMO/DMO ☐ UNION ☐ WELFARE ☐ DISCOUNT PLANS ☐ CASH	☐ PPO ☐ HMO/DMO ☐ UNION ☐ WELFARE ☐ DISCOUNT PLANS ☐ CASH
(11) Name of insurance co.		
(12) Insurance plan code		
(13) Insurance effective date		
(14) Group number		
(15) Member I.D.#		
(16) Employer's name		
(17) Employer's address		
(18) Employer's phone #		

(19) STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED/DIVORCED

(20) SPOUSE OR PARENT'S NAME: _____

(21) IF THE PATIENT IS A MINOR, NAME OF THE PARENT/GUARDIAN:_____

(22) RELATIONSHIP WITH MINOR:_____

(23) SECONDARY CONTACT #: ☐ CELL ☐ HOME ☐ WORK :_____

(24) E-MAIL:_____

(25) ADDRESS: (STREET/APT):_____

CITY:_____ STATE:_____ ZIP:_____

(26) EMERGENCY CONTACT NAME :_____ NUMBER: _____

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Patient Medical History

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Physician's Name: ..... **Phone :** .....

Pharmacy Name: ..... **Phone :** .....

YES NO Check ☑ the Appropriate Answer

- ☐ ☐ Are you presently taking any medications or drugs?
  If yes, Please List: .....
- ☐ ☐ Are you allergic to Latex? Local Anesthesia? Or other materials?
  If yes, Please List: .....
- ☐ ☐ Are there any medications you cannot take?
  If yes, Please List: .....
- ☐ ☐ Do you have any bleeding disorders?
  If yes, Please List: .....
- ☐ ☐ Have you ever had prolonged bleeding from extraction of teeth or injury?
- ☐ ☐ Do you have any autoimmune disorders?
  If yes, Please List: .....
- ☐ ☐ Do you have any nervous disorders?
  If yes, Please List: .....
- ☐ ☐ Do you have any artificial Prosthesis?
  If yes, Please List: .....
- ☐ ☐ Do you use tobacco in any form? If yes, how much? .....
- ☐ ☐ Do you use alcoholic beverages? If yes, how much? ..... How often? .....

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS or HIV Positive	☐	☐	Thyroid condition	☐	☐	Heart Murmur
☐	☐	Hepatitis	☐	☐	Artificial joints/limbs	☐	☐	Heart Attack or Coronary Surgery
☐	☐	Emphysema	☐	☐	Arthritis	☐	☐	Mitral valve prolapse
☐	☐	Tuberculosis	☐	☐	Shortness of breath	☐	☐	Artificial Heart valve
☐	☐	Asthma / Hay fever	☐	☐	Sinus problem	☐	☐	Pacemaker
☐	☐	Rheumatic fever	☐	☐	Headache	☐	☐	High or Low Blood Pressure
☐	☐	Cancer or Tumors	☐	☐	Kidney disease	☐	☐	Angina
☐	☐	Radiation treatment	☐	☐	Venereal disease	☐	☐	Diabetes
☐	☐	Chemotherapy	☐	☐	Herpes	☐	☐	Ulcers
☐	☐	Stroke						
☐	☐	Seizures, Convulsions, or Epilepsy						

PLEASE LIST ANY OTHER HEALTH INFORMATION OR MEDICAL CONDITIONS, NOT LISTED ABOVE WHICH MAY INFLUENCE YOUR DENTAL TREATMENT:

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PATIENT
D.O.B.
INS COMP

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Patient Dental History

Yes No

- ☐ ☐ Are there any dental problems you are currently having that you feel need immediate attention?
  If yes, please describe:_____
- ☐ ☐ Have you ever had treatments for your gums?
- ☐ ☐ Do your gums bleed or hurt when you brush them?
- ☐ ☐ Do your teeth hurt when you chew?
- ☐ ☐ Have you ever had orthodontic treatment or worn braces?
- ☐ ☐ Have you ever been aware of a bad odor or taste in your mouth?
- ☐ ☐ Are your teeth sensitive to hot, cold, or sweets?
- ☐ ☐ Do you clench or grind your teeth during the day or night?

Female Only

Yes No

- ☐ ☐ Are you now or think you may be pregnant?
- ☐ ☐ Are you nursing?
- ☐ ☐ Are you presently taking birth control pills?

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand taht providing invorrect information can be dangerous to my health. I authorize the dentist to relase any information including the diagnosis and the recordes of any treatment or examination rendered to me or my child or person under my care during the period of such dental care to third party payers and/or health practioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the acutal bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____ Date_____
(Patient or guardian)

Future Medical History Update

Reviewed By_____Date_____
Dentist

Patient/Guardian Signature	*Date*	*Dentist Signature*	*Date*	*Notes/Remarks*

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PATIENT
D.O.B.
INS COMP

DATE/TIME

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Financial Policy

1. PATIENTS WITH INSURANCE COVERAGE

Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments of your account. We can request a pre-estimate of benefits from your insurance carrier if you request us to do so. Routine treatments are generally performed without submitting a request of pre-estimate of benefits.

Regarding insurance plans where we are a participating provider, **all co-pays and deductibles are due prior to the treatment.** If your insurance company has not paid the claim within forty-five (45) days, the balance will be automatically transferred to you. In some cases, insurance carriers may pay for alternative benefits than the treatment performed. In this case you are responsible to pay the difference. Even if you have dual coverage there may still be a portion that is your responsibility. All procedures involving lab work will require fifty-percent (50%) down payment, then the remaining fifty-percent (50%) balance will be due at the day of final insertion. If you are having treatment over a period of time, we appreciate your payment during the course of treatment. Our financial coordinators will assist you in arranging a payment schedule.

2. PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are required to pay for services as rendered. We accept cash, MasterCard, Visa, Discover, American Express or Debit/ATM cards. We also arrange pre-payments and financing plans.

3. ALL PATIENTS

a. Unless other arrangements have been made in advance, **all co pay and deductibles must be paid at the time of service.** You may have to pay approximate payment towards the co-payment for the dental treatments. We update your balance, if any, towards your future treatments. It is your responsibility to request our office or a statement of accounts or a refund of your credit balance.

b. Checks returned unpaid from the bank are subject to a thirty-dollar ($30.00) service fee.

c. Any account delinquent more than sixty (60) days from the date of billing are subject to a 1.5% per month, or eighteen-percent (18%) annual finance charge. If your account is sent to our collection agency, you will be responsible for collection and any court costs along with attorney's fees.

d. In the event that you chose to terminate your treatment, for any reason, you will remain liable for any interest and/or financing charges incurred by you on your behalf in connection with the financing of your treatment plan. For example, if you have borrowed the treatment amount of one-thousand dollars ($1,000.00), and if there is a ten-percent (10%) interest/finance charge charged to our company by the lending company on your behalf, if you decide to alter and/or cancel the treatment plan and request us to return the funds back to the lending company, you will be liable for the interest/finance charges that we have paid on your behalf, in this example one-hundred dollars (100$) will be charged to you.

Patient Name_____ Date_____

Signature of Patient or Parent/Guardian_____

OFFICE
PATIENT
D.O.B.
INS COMP

DATE/TIME

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Dental Office Informed Consent

It is very important to us that you, our patient, understand the treatment we are recommending and any invasive procedures which we may, with your agreement, perform. We want to involve you in all decision concerning any invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form as you understand that there is risk associated with dental procedures and all of your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk of complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body, there are potentially many variables, some predictable and others not. Complication rates in dentistry are low but they do exist. Even minor procedures such as "fillings" can lead to major complications that can't be foreseen. For example, a "Novocain" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to nerve problems, abscesses, fractured teeth, and/or post treatment pain when biting and with temperature extremes. These complications can be transient or may persist requiring further treatments.

The above examples are only samples of possible complications with dental treatment and are not limited to these examples. In general, complications include but are not limited to pain, swelling, bleeding, infection, fractures and other nerve problems.

I have read, understand and consent to dental treatment.

Patients Name_____ Date_____

Signature of Patient or Parent/Guardian _____

Management Disclaimer

This office is managed by a Dental Practice Management Group. We are not responsible for the clinical procedures, diagnosis, and/or treatment plan performed by the treating dentist. This office utilized the services of both general and specialty dentists in order to provide patients with convenient and timely treatment in accordance with the standard of care recognized in this professional community. The general and specialty dentists in our offices are duly licensed independent contractors who are personally responsible for your diagnosis, treatment plan and clinical services. The dentist(s) treating you has made his or her own evaluation of your dental health and will discuss with you an appropriate treatment plan. Any questions or concerns you may have about your clinical treatment should be directed to the treating dentist. The administrative personnel are employed by this office to provide scheduling, billing, and other office administrative functions and are not licensed to give medical advice. The treating dentist is solely responsible for your dental treatment and this office requires that each dentist maintain adequate professional liability insurance for this purpose. **By signing this form, you acknowledge and understand that the treating dentist(s) is an independent contractor and is solely responsible for your treatment.**

Patients Name_____ Date_____

Signature of Patient or Parent/Guardian _____

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Patient Consent For My Provider To File A Grievance On My Behalf With My Health Insurance Plan

Provider name: SmileKrafters	Provider plan ID number N/A
Provider address: 1247 S. Cedar Crest Blvd., Allentown, PA 18103	
Description of services that may be appealed	Date(s) services were proviced N/A

I agree to allow this health care provider to file a grievance on my behalf with the following health plan if there is a question about coverage for the services listed below:

I understand that:

1. If I consent, I will not be able to file my own grievance concerning these same services, nor will any represent I appoint.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file a grievance, or stops grieving my case.

I have read this consent or have had it read to me, and it has been explained to my satisfaction.

I understand the information in the consent form, and grant my consent to this provider to file a grievance on my behalf.

Print patient name:	Patient date of birth:	Health insurance company
Patient address		Patient Insurance ID number
Patient signature		Signature date

OFFICE
PATIENT
D.O.B.
INS COMP

DATE/TIME

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Gateway Health Plan

US Steel Tower, Floor 41
600 Grant Street, Pittsburg, PA 15219-2704
Facsimile 412/255/4503

Consent for Provider to file a Grievance on my behalf

Provider Name: _____ Provider Plan ID: _____

Provider Address: _____

Description of services that may be appealed: _____

_____

Date(s) services were provided: _____

I agree to allow this health care provider file a grievance on my behalf with Gateway Health Plan®. If there is a question about coverage for this services listed above, I understand the following:

- If I consent, I will not be able to file my own grievance concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing
- I have the right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time
- This consent shall be automatically rescinded if my health care provider does not file a grievance, or stops grieving my case.

I have read this consent form or someone has read it to me, and it has been explained to my satisfaction.

I understand the information in the consent form and grant my consent to this provider to file a grievance on my behalf.

Patient Name: _____ Date of Birth: _____

Address: _____

Gateway Health Plan® ID Number: _____

Witness Name: _____

Witness Signature _____

Relationship _____ Date _____

For members who are minors, under the age of 18, or otherwise unable to sign:

Member_____ is unable to sign for the following reasons:

_____

_____

and I consent for the above named member:

_____
Representative signature Date

_____
Representative printed name Relationship to member

_____
Representative address

_____
Representative telephone number

_____
Witness signature Date

_____
Witness printed name

SMILEKRAFTERS
WE'RE ALL HERE FOR YOU

Your Name _____ Date _____

How did you hear about SmileKrafters?

☐ Referred by family or friend

Their name _____

☐ Referred by other doctor/dental office

Office name _____

☐ Referred by another SmileKrafters department

Deparment name _____

☐ Online/Internet search

Website name _____

☐ Community event

Event name _____

☐ Lehigh Valley Phantoms

☐ TV commerical

Station Name (i.e. PBS 39, Channel 69) _____

☐ Magazine ad

Magazine Name _____

☐ Other

Please Specify _____

SMILEKRAFTERS
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We understand that all of our patients have unique and busy schedules. Here at SmileKrafters, we do our best to accommodate our patients by offering a variety of appointment times.

In order to provide the best treatment possible, certain procedures require longer appointment times and are only scheduled in the morning or early afternoon.

Please refer to the following information regarding specific treatment and corresponding appointment times.

Please note **ALL SERVICES ARE OFFERED BY APPOINTMENT ONLY - WE CANNOT ACCEPT WALK IN PATIENTS**

Arch Wires (STANDARD MONTHLY APPOINTMENTS):
Tuesdays – 8:00am to 6:00pm - Thursdays –7:30am to 6:00pm -
20 to 30 Minute Appointments

Banding/ Start of Braces:
Mornings and Early Afternoons –7:30am to 3:00pm
1.5 Hour Appointments

New Patient Appointments:
Monday through Thursday - Anytime

Removal:
Mornings and Early Afternoons –8:00am to 2:00pm
1 Hour to 1.5 Hour Appointments

Repairs:
Mornings and Early Afternoons –8:00am to 2:00pm
45 Minute Appointments

Retainer Delivery:
Next Day – 10:00am to 1:00pm –
15-30 Minute Appointments

Thanks for your understanding and cooperation!
- The Orthodontic Team at SmileKrafters