Signature Smiles Family Dentistry

6740 Rock Spring Road | Suite 210 • Wilmington, NC 28405
office@sigsmilesfd.com
(910)256-9141

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ * (Last) _____ * (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ * (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ * (Address 1) _____ (Address 2)

_____ * (City) _____ * (State) _____ * (Zip Code)

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

Spouse/Responsible Party Information/Insured Subscriber

The following is for:* ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ * (Last) _____ * (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* _____ **Email Address:** _____

Phone: _____ * (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ * (Address 1) _____ (Address 2)

_____ * (City) _____ * (State) _____ * (Zip Code)

Employment Information

The following is for:* ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name:* _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____* _____* _____
Last First MI

Insured's Birth Date:* _____ **ID #:*** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name:* _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Relationship to Patient: *

HIPPA COMPLIANCE CONSENT

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

Allowed Family Members *

_____

_____

_____

_____

_____

Signature _____ **Date** _____

Signature Smiles Family Dentistry

Office Financial Policy

Thank you for choosing Dr. Veronica Taylor-Williams as your dental professional. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible.

Payment Options:
-Cash, Check, Visa, and Mastercard
-We offer a courtesy discount to patients who do not have dental insurance but pay for their treatment on the day of service.
-Convenient monthly payment plans are also available through Care Credit - this allows you to pay over time with no annual fees or pre-payment penalties.

Please note:
-Payment is due upon check out! Signature Smiles requires payment on day of service. This includes patients with insurance as well as self-pay patients.
-For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill for your treatment as a courtesy to you.
-A $25 fee will apply for any returned checks
-If we do not receive payment from your insurance carrier within 120 days of treatment, the patient will be responsible for any unpaid fees.
-A $50 fee will be charged to all patients who miss/cancel their appointment with less than 24 hrs notice. Patients can be dismissed from the practice after 3 missed appointments.
-We do not offer in house financing or payment plans, but we are more than happy to accept two separate payments for 2 visit procedures. (Crowns, Bridges, Dentures, and Partials)

If you have any questions, please do not hesitate to ask! We are happy to help you achieve the smile of your dreams!

Signature _____ **Date** _____

Response Date: _____

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Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

- [ ] AIDS/HIV
- [ ] Allergies - Acrylic
- [ ] Allergies - Aspirin
- [ ] Allergies - Latex
- [ ] Allergies - Loc Anes
- [ ] Allergies - Metal
- [ ] Allergies - Penicill
- [ ] Allergies - Sulfa
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Angina
- [ ] Arithromyacin
- [ ] Arthritis/Gout
- [ ] Artificial Heart Val
- [ ] Artificial Joints
- [ ] Aspirin
- [ ] Asthma
- [ ] Back Pain
- [ ] Back Problems
- [ ] Barbiturates
- [ ] Blood Disease
- [ ] blood thinners
- [ ] Blood Transfusion
- [ ] Breathing Problems
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Celebrex
- [ ] Chemotherapy
- [ ] Chest Pains
- [ ] Codeine
- [ ] Cold Sores
- [ ] Congenital Heart
- [ ] Convulsions
- [ ] Cortisone Medication
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Epilepsy or Seizures
- [ ] Excessive Bleeding
- [ ] Fainting/Dizziness
- [ ] Flagyl
- [ ] Freq Cough
- [ ] Freq Diarrhea
- [ ] Freq Headaches
- [ ] Genital Herpes
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Heart Attack
- [ ] Heart Murmer
- [ ] Heart Pacemaker
- [ ] Heart Trouble/Diseas
- [ ] Hemophilla
- [ ] Hep A
- [ ] Hep B or C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hives or Rash
- [ ] Hypoglycemia
- [ ] Iodine
- [ ] Irregular Heartbeat
- [ ] Kidney Problems
- [ ] Latex
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Local Anesthetic
- [ ] Low Blood Pressure
- [ ] Lung Disease
- [ ] Mental Health Issues
- [ ] Mitral Valve Prolaps
- [ ] naproxine
- [ ] Nickel
- [ ] Osteoporosis
- [ ] Pain in Jaw Joints
- [ ] Penicillin
- [ ] PRE-MED
- [ ] red dye
- [ ] red dye, no topical
- [ ] Shortness of Breath
- [ ] sleep apnea
- [ ] Stroke
- [ ] Sulfa
- [ ] Swelling of Feet/Ank
- [ ] Thyroid issues
- [ ] Venereal Disease

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Response Date: _____

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Consent for Internet Communications

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

Response Date: _____