Magical Smiles Family Dentistry

FOR OFFICE USE ONLY

Patient Registration Form

Contact Information (Self/Parent/Guardian)

Name: _____ Date of Birth: _____
Last First Middle Initial

Address: _____
Street/Apt # City State Zip Code

Telephone: Home: _____ Cell: _____ Work: _____

Email: _____ Gender: Male/Female

Preferred Method of Contact (Check One) Home ☐ Cell ☐ Work ☐ Email ☐

Relation: _____
Patient/Father/Mother/Legal Guardian

Patient Name	DOB	Patient Name	DOB

Guardian Information – For Minors (under 18) or if the patient cannot consent to their own treatment

Guardian (2) Name: _____ Date of Birth: _____

Address (If different from Patient): _____

Telephone: H/C/W _____ Relation: _____
Father/Mother/Legal Guardian

Primary Insurance

Policy Holder Information:

Full Name: _____

Date of Birth: _____

Plan Name: _____

ID & SSN: _____

Group #: _____

Phone #: _____

Secondary Insurance

Policy Holder Information:

Full Name: _____

Date of Birth: _____

Plan Name: _____

ID & SSN: _____

Group #: _____

Phone #: _____

EMERGENCY CONTACT – In case of a medical emergency, who may we contact?

Name: _____ **Phone:** _____ **Relation:** _____

I certify that all of the above Information is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____
Patient/Parent/Legal Guardian

Interpreter/Witness Name: _____ **Phone #:** _____

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MEDICAL HISTORY UPDATE

PATIENT NAME: _____ DOB: _____

FAMILY DOCTOR: _____ FAMILY DOCTOR PHONE: _____

CHECK THE BOXES BELOW IF: YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX		DIABETES		HERPES		PSYCHIATRIC TREATMENT	
AIDS/HIV		DIZZINESS		HIGH BLOOD PRESSURE		RADIATION TREATMENT	
ADD, ADHD, ODD		DOWNSYDROME		HYPOGLYCEMIA		RESPIRATORY PROBLEMS	
ALLERGIES:		EMPHYSEMA		HYPERGLYCEMIA		RHEUMATISM	
ANEMIA		EPILEPSY		HYPERTHYROIDISM		SCARLET FEVER	
ARTHRITIS		EXCESSIVE BLEEDING		HYPOTHYROIDISM		SEIZURES	
ARTIFICIAL JOINTS/IMPLANTS		FAINTING		INTESTINAL DISORDERS		SINUS PROBLEMS	
ASTHMA		FEVER BLISTER/COLD SORES		KIDNEY DISEASE		SJORGENS SYNDROME	
AUTISM		GLAUCOMA		LIVER DISEASE		SMOKING/CHEW TOBACCO	
BIRTH DEFECTS		HAY FEVER		LOW BLOOD PRESSURE		STOMACH PROBLEMS	
BLEEDING DISORDER		HEAD/FACE INJURIES		MENTAL DISORDERS		STROKE	
BLOOD TRANSFUSION		HEARING DISORDERS		MIGRAINES		SUBSTANCE ABUSE	
C-PAP MACHINE		HEART ATTACK		MITRAL VALVE PROLAPSE		TUBERCULOSIS	
CANCER – TYPE		HEART DISEASE		MONONUCLEOSIS		TUMORS	
CONGENITAL HEART DISEASE		HEART MURMUR		NERVOUS DISORDERS		ULCERS	
COSMETIC SURGERY		HEART PROBLEMS		NUMBNESS OF ARMS/HANDS			
CROHN'S		HEART SURGERY		OSTEOPOROSIS			
DEVELOPMENTALY DELAYED		HEPATITIS – TYPE A, B, C		PNEUMONIA			

PLEASE LIST ALL **PRESCRIPTION AND OVER THE COUNTER MEDICATIONS** WHICH ARE CURRENTLY TAKING: _____

_____

HAVE YOU HAD ANY MAJOR SURGERIES: _____

_____

DO YOU HAVE HEALTH PROBLEMS OR DISEASES NOT LISTED ABOVE OR THAT NEED FURTHER CLARIFICATIONS? YES/NO

IF YES, PLEASE EXPLAIN: _____

_____

ARE YOU CURRENTLY TAKING BLEOMYCIN (CANCER MEDICATION)? YES /NO

IS THERE ANY ALERGIES TO PENICILLIN OR OTHER DRUGS? YES/NO

IF YES, WHICH DRUGS/MEDICATIONS: _____

DO YOU HAVE ANY EMOTIONAL/PSYCHOLOGICAL PROBLEMS? _____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORAMION THAT OUR OFFICE SHOULD BE AWARE OF AT THIS TIME: _____

WOMEN:

ARE YOU CURRENTLY PREGNANT? YES/NO DUE DATE: _____ BIRTH CONTROL? YES/NO

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Revised 05/27/15 amd

Magical Smiles Family Dentistry

FINANCIAL POLICY

USUAL AND CUSTOMARY RATE (UCR)
Our practice is committed to providing the best treatment possible for our patients. Our relationship is with you, not your insurance carrier. While the filing of insurance claims is a courtesy we provide to our patients, all charges are your responsibility from the date of service that are rendered. Keep in mind, that the rates paid by your insurance carrier are determined by the insurance carrier and your employer and, in some situations, have no bearing on the real *usual* and *customary* rates charged in the local areas.
Although your policy may state you have 100 percent coverage on either preventive or basic services, be aware that you may still have an out-of-pocket cost, which may include your annual deductible and may have an annual maximum paid.
Any information our office gives you regarding your insurance coverage is an estimate. We make these estimates based on information available to us. We are not responsible for any decisions regarding payment that the insurance carrier makes.

PAYMENT IS DUE AT TIME OF SERVICE: Payment Options: Cash, Check, MasterCard/Visa/Care Credit.

PATIENTS WITH INSURANCE: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the services.

PARENTS NOT ACCOMPANYING THEIR CHILD to an appointment must make PRIOR arrangements for payment.

DIVORCES: Both partners are responsible for debts incurred up to the dare of the divorce decree. If a dispute over payment arises after the divorce is final, we must have a copy of the divorce decree. The parent who requests treatment for a child is responsible for balance of services rendered for your child.

OFFICE POLICY

APPOINTMENT FAILURES AND CANCELLATIONS:
If a patient fails to show for their appointment more than twice or if they cancel their appointment less than 24 hours' notice consecutively you will be dismissed from Magical Smiles and a fee may be charged for all appointment failures and cancellations.
In addition, we are a family-oriented office and we want to emphasize and remind everyone the importance of practicing proper manners while at Magical Smiles Family Dentistry. We have ZERO tolerance policy for Rudeness or Misconduct towards the staff. If a patient, caregiver or significant other exhibits a lack of courtesy towards a team member, immediate and permanent dismissal from Magical Smiles Family Dentistry will be given.

Signature:_____

Magical Smiles Family Dentistry

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges and dentures), orthodontics, restorative dentistry, oral pathology, pediatric dentistry and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about my aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

7. I have received and agreed to the cancellation, financial and privacy polices of Magical Smiles.

_____ _____

Patient/Parent/Legal Guardian (Print) Patient/Parent/Legal Guardian (Signature)

_____

Date

408 Dix Road Jefferson City, MO 65109 Phone: 573.638.3897

TRUTH IN LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	10.00%
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	If you are charged interest, the charge will be no less than $1.00

FEES	
Late Charge	$1.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $5.00
Non-Sufficient Funds (NSF) Fee	$25.00 per payment

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Magical Smiles
Dental Entity Name

Signature Date

Print Name

A photocopy of this document may act as an original