PATIENT REGISTRATION

Patient's Name: _____ Nickname: _____ Birthdate: _____

Cell # (unlimited emojis!): _____ Home # (who still has this?): _____

Email Address (no spam!): _____ Social Security #: _____

Home Address: _____ Apt/Unit #: ___ City: _____ State: __ Zip: _____

Please Circle: Single – Married Gender: M – F Type of Reminders: Text – Email – Phone

Your Employer: _____ Occupation: _____ Years Employed: _____

Spouse's Name: _____ Spouse's Occupation: _____ Work #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about our office? (who can we thank?) _____

Guardian/Responsible Party (if different than patient): _____ Relationship: _____

DOB: _____ Social Security #: _____ Cell Phone: _____

DENTAL INSURANCE

Subscriber's Name: _____ DOB: _____ Relationship to patient: _____

Subscriber's SSN: _____ Employer: _____

Insurance Company: _____ Group #: _____

SECONDARY DENTAL INSURANCE

Subscriber's Name: _____ DOB: _____ Relationship to patient: _____

Subscriber's SSN: _____ Employer: _____

Insurance Company: _____ Group #: _____

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may fully attain optimal oral health. Please understand that payment of your bill is considered part of your treatment and payment is due at the time of scheduling. Financing is available upon request and approval. Personal checks are not accepted. Returned checks will be subject to an additional fee of $100 and is against Nevada State Law. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges. Please take note:

- We will help you process all your insurance claims as a courtesy to you. Understand that we will provide an insurance estimate to you, however, it is NOT a guarantee that your insurance will pay exactly as estimated. Insurance companies are full of tricks and policies designed to save their profits and not help you. Your insurance company and your plan benefits ultimately determine the cost of treatment. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges incurred are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. By the same token, your insurance company isn't concerned with your oral or overall health. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

- Our practice is committed to providing the best treatment for our patients and our fees are equivalent to what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute, legal or otherwise, with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY MEDICAL AND/OR DENTAL INSURANCE COMPANY TO PAY MY MEDICAL/DENTAL BENEFITS DIRECTLY TO THIS DENTAL OFFICE.

CONSENT

The undersigned hereby authorizes Smiles for Life Family Dentistry and its providers to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize and give my informed consent to Smiles for Life Family Dentistry and it's providers to perform any and all forms of treatment, medication and therapy that may be indicated in my best interest. I understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for all services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Patient Signature (or parent): _____ Date: _____

SMILES FOR LIFE
FAMILY DENTISTRY

MEDICAL HISTORY

SMILES FOR LIFE FAMILY DENTISTRY

NAME: _____

ADDRESS: _____ Cell #: (____)_____

Please check any of the following conditions that apply to you:

- ☐ ADD / ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Back Pain
- ☐ Cancer
  Date: _____
  Radiation:
  YES / NO
- ☐ Clotting Disorder
- ☐ Depression
- ☐ Diabetes
- ☐ Dry Mouth
- ☐ Drug Addiction
- ☐ Eating Disorders
- ☐ Fainting
- ☐ Heart Conditions
- ☐ Heart Surgery
  Date: _____
- ☐ Hepatitis B / C
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV Positive/AIDS
- ☐ Jaw Pain
- ☐ Joint Replacement
  Date: _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Pacemaker
- ☐ Pregnant
  Due: _____
- ☐ Seizures
- ☐ Sinus Disorders
- ☐ Sleep Apnea
- ☐ Stomach Disorders
- ☐ Stroke
- ☐ Teeth Clenching/Grinding
- ☐ Tooth Pain
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ COVID-19 (or knowingly interacted with someone who has tested positive)
- ☐ COVID-19 Vaccination
  1st Dose: _____
  2nd Dose: _____
- ☐ Other: _____
  _____
  _____

Do you have any of the following allergies?

- ☐ Aspirin
- ☐ Codeine
- ☐ Hydrocodone
- ☐ Ibuprofen
- ☐ Latex
- ☐ Nitrous Oxide
- ☐ Penicillins
- ☐ Sulfa
- ☐ Triazolam
- ☐ Valium
- ☐ Other: _____
  _____

LIST ANY CURRENT MEDICATIONS BELOW:

Medication	Reason

Do you smoke or chew tobacco? YES / NO
How much? _____ For how long? _____

Have you knowingly had a temperature over 100°F within the last week? YES / NO

Current temperature: _____ °F

Patient Signature (Guardian, if child): _____ Date: _____

Dentist Signature: _____

Smiles for Life Family Dentistry www.lvsmilesforlife.com 8930 W. Sunset Rd. Ste. 190 Las Vegas, NV 89148 (702)795-2273

SMILES FOR LIFE
FAMILY DENTISTRY

CANCELLATION POLICY

We ask that you kindly and considerately provide us with at least 24 hours of notice prior to your scheduled appointment time in order to re-schedule. A phone call or text during business hours is the only acceptable method. After-hours voicemails will not be accepted.

At Smiles for Life Family Dentistry, we value your time and realize how important that time is. When you schedule an appointment with us, that time is reserved specifically for you and the rest of the schedule is altered to accommodate your needs. We try our very hardest to be punctual and to not have you waiting past your scheduled appointment time.

We realize that sometimes emergencies arise. However, if you do not show up to your scheduled appointment, or cancel without sufficient notice, that leaves an unusable gap in our schedule which could have been filled by someone needing our care. The time of the Dentist, the Hygienist and the Team are very valuable as well and not providing us with adequate notice doesn't allow us the opportunity to care for another patient nor allow us to recover the lost revenue from the missed appointment. Based upon these facts, and at our discretion, your account may be charged a fee between $25-$200 per occurrence depending on how many hours you were scheduled for. For longer appointments, a non-refundable deposit may be required to secure a position in the schedule.

If a Saturday or another off-day appointment is scheduled, there will be a $50 refundable deposit to hold a hygiene appointment and a 100% NON-refundable deposit for any treatment.

We thank you for your consideration and appreciate your mutual respect.

Sincerely,

Smiles for Life Family Dentistry and its patient families

Patient Signature (or Guardian): _____ Date: _____

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 Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign ☐

Communications barriers prohibited obtaining the acknowledgement ☐

An emergency situation prevented us from obtaining acknowledgement ☐

Other (Please Specify) _____
_____

_____ _____
Employee Name Office Name

_____ _____
Employee Signature Date