All Smiles Dental Care

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201 West 2nd Street | PO Box 343 • Minneapolis, KS 67467 (785)392-2194

Welcome to All Smiles Dental Care!

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)

Dental History

What is the primary dental concern for your child?

_____

_____

Has your child ever been to the dentist? ◯ Yes ◯ No

If Yes, when was their last visit and for what?

_____

_____

Has your child:

- ☐ Had any dental work?
- ☐ Had a bad dental experience?
- ☐ Ever been diagnosed with a cavity?
- ☐ Had any orthodontic treatment?
- ☐ Had any trauma to the face/mouth?

Development

Do you have any concern about your child's:

- ☐ Speech
- ☐ Sleep Habits
- ☐ Chewing Function
- ☐ Tooth Placement or Appearance

Nutrition/Habits

How many times a week does your child:

Go to bed with a bottle or sippy cup?

☐ 1-2 ☐ 3-5 ☐ 5 or more

Consume juice, soda, sports drinks, lemonade or other sugary drinks?

☐ 1-2 ☐ 3-5 ☐ 5 or more

Eat candy, dried fruit, fruit snacks, pastries, cookies or other sugary snacks?

☐ 1-2 ☐ 3-5 ☐ 5 or more

Does your child:

- ☐ Complain of pain when chewing food?
- ☐ Choke on food frequently?
- ☐ Suck their thumb?
- ☐ Use a pacifier?
- ☐ Drink from a fluoridated water suppy?
- ☐ Have a routine for brushing and flossing?

Sleep Habits

Does your child:

- ☐ Frequently wake up at night (in an 8 hr period)?
- ☐ Frequently snore?
- ☐ Grind their teeth?
- ☐ Seem inattentive or irritable during the day?
- ☐ Still seem tired when waking in the morning?
- ☐ Have dark circles under their eyes?
- ☐ Have night terrors?
- ☐ Experience bed wetting?
- ☐ Breathe loudly through their mouth instead of their nose?

Parents

Do YOU:

- ☐ Have any cavities or history of tooth decay?
- ☐ Have bleeding gums?
- ☐ Have a dental homecare routine established?
- ☐ Share cups, eating utensils, straws, etc with your child?

HIPPA Ackowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
*

☐ I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.

Consent for Internet Communications

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 understand the dental practice cannot and does not assume any responsibility for my use or misuse of patient information or other information transmitted, monitored, stores, 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.

All Smiles Office Policies

PATIENT INFORMATION

It is our policy that we update your medical history at each appointment. Please bring an updated medication list with you. Please notify us of any changes. Patient information packets are typically updated every five years at the same time as your comprehensive exams. This will soon be available to do on our website for you to fill out prior to your appointment to save you time if you prefer. HIPAA Policy We value your health information and we do everything possible to protect your personal information. HIPAA provides protection of your health information.

APPOINTMENT COMMITMENT

We value your time and ask that you value ours as well. Therefore, we try to make our schedule predictable! If you are late, you may have to be rescheduled or wait until we are available. If you are unable to make it on the day and time you had reserved, we ask for a 48 hour notice so we may offer that time to other patients. If you have received an appointment commitment letter from us for repeated scheduling conflicts, you are required to confirm your appointment within 48 hours or it will be removed from the schedule.

COURTESY CONFIRMATIONS

With our new software we will be able to sync email and text confirmations if you choose. Our team can continue to phone as well. Please be sure to let us know your preference.

MISSED APPOINTMENTS

Missed appointments result in an inability to provide care to others who could have been seen in that time and increase the cost of care for others. We understand that life happens, but we ask that you call us as soon as you realize there is a conflict. Multiple last minute missed appointments will result in a dismissal from our practice.

INSURANCE

We accept all insurance plans and contracted providers with Delta Dental, Blue Cross Blue Shield of Kansas and the Sunflower KanCare program. If you need help in determining what your plan covers our team is here to assist you or you can call th

RETURNED CHECKS

Checks returned as "Insufficient Funds" will be assessed a $30 service charge in addition to being contacted for payment in cash or a money order.

LAB CHARGES

All orders that require the use of an outside lab, such as crowns, dentures or appliances, require a minimum 50% deposit before they will be processed and the balance is due in full upon delivery since they are custom made.

BILLING STATEMENTS

Statements will be mailed every Friday for the treatment completed that week and will be due in twenty days. You will only receive one if you have not in the last 30 days. If an insurance claim is processing, the insurance estimate will show on your statement along with your patient portion separate. Every quarter, we assess credits and refund patients accordingly if insurance has closed.

FINANCE CHARGES & PAST DUE ACCOUNTS

A 10% finance charge is assessed on delinquent accounts over 60 days. Accounts 120 days past due will be transferred to our collection agency for legal action.

MINOR CHILDREN

If a minor child comes alone for an appointment, it is required the parent is easily and readily available by phone for verbal permission of treatment. If a minor child comes alone for an appointment, call ahead to arrange any payment for services and have their patient information paperwork done prior.

DIVORCED PARENTS

The person who brings a minor child to an appointment is responsible for paying for the services. Please understand, we cannot be responsible for collecting partial payments form another individual. Any court ordered agreement is between the divorced parties. *

☐ * I acknowledge that I have read All Smiles Dental Care's office policies and know that in order to receive optimal care as a patient that I must choose compliance.

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

Name:

Last First MI

Preferred Name

Title: **Gender:** Male Female

Mr/Ms/Mrs/etc

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:

SS#: **DL#:** ___-__-____

Email Address:

Best time to call:

Phone:

Home Mobile Work Ext

Fax Other

Address:

Address 1

Address 2

City State Zip Code

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

Insurance Authorization:

☐ ***I authorize my insurance to pay my benefits directly to the dentist for all services rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by 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

Insurance Authorization

☐ *

I authorize my insurance to pay my benefits directly to the dentist for all services rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

Response Date: