ONECO SMILES
General and Cosmetic Dentistry

# Patient Demographics and Insurance Information

**Patient Information:**

Name (First, Last): _____ Preferred Name: _____

Address: _____

City, State, Zip: _____

Cell: _____ Alt phone: _____ Occupation: _____

Date of Birth: _____ Social Security: _____

E-mail Address: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other

**Emergency Contact** Name & Phone: _____

Relationship to Patient: _____

**Physician's** Name & Phone : _____

Who may we thank for referring you to our office? _____

**Preferred Pharmacy:**

Name: _____ Location: _____ Phone Number: _____

**Financial Responsibility**: Payment is due at time of service. If the person responsible for payment on the account is **other than** the patient, please fill out the following information.

Responsible party: ☐ Spouse ☐ Parent ☐ Other _____

Name (First, Last): _____

Address: _____ Phone: _____

**Dental Insurance Information**:

Insurance Company Name: _____

Ins. Co. Address and Phone: _____

**Subscriber Information:**

Who is the policy holder on this insurance plan? ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Policy Holder Name (First, Last): _____

Policy Holder Member ID or SSN: _____ Policy Holder DOB: _____

**Employer**: _____ Group/Plan # _____

ONECO SMILES
General and Cosmetic Dentistry

Today's Date:_____

# Medical and Dental Questionnaire

Patient Name: _____ Date of Birth:_____

**Reason for Visit**: Please check all that apply.

☐ New Patient ☐ Existing Patient ☐ Second Opinion ☐ Cleaning ☐ Annual Check Up ☐ Treatment (with dentist)

☐ Pain/Toothache ☐ Esthetic concerns ☐ Other: _____

**Allergies and Sensitivies:** Please check if you have been advised **not to take or be exposed to the following.**

☐ Penicillin/ Amoxicillin ☐ Ibuprofen/ Aspirin (NSAIDS) ☐ Non-precious metals ☐ Latex ☐ Epinephrine

☐ No known allergies ☐ Other: _____

**Social and Dental:** Please check all that describe your **habits** or things that you **notice about your mouth.**

☐ Tobacco ☐ Alcohol ☐ Recreational drugs ☐ Suck on cough drops/ candy ☐ Sip on drinks ☐ Chew ice ☐ Snack frequently

☐ Bite nails ☐ Brush twice daily ☐ Floss daily ☐ Clench/grind teeth ☐ Dry mouth ☐ Dental Pain ☐ Cavities

☐ Cold sores ☐ Gum disease ☐ Use hard toothbrush ☐ Bite guard ☐ Whiten teeth ☐ Missing teeth ☐ Trouble chewing

☐ Jaw problems (TMD) ☐ Snore ☐ Mouth breather ☐ Other: _____

**Medical History and Treatment**: Please check all that apply and provide clarifying information.

☐ Anaphylaxis
☐ Antibiotic premed for dental appointments
☐ Artificial Heart Valve
☐ Asthma
☐ Bisphosphonates (e.g. Boniva, Fosamax)
☐ Bleeding disorder
☐ Cancer: If so, what type?
_____
☐ Chemotherapy
☐ Dental-related anxiety
☐ Diabetes: If so, what type?
_____
☐ Emphysema/COPD
☐ Glaucoma
☐ Head & neck radiation
☐ Heart disease
☐ HIV
☐ Memory issues
☐ Osteonecrosis of the jaw
☐ Osteoporosis/ Osteopenia
☐ Seizures
☐ Sleep apnea
☐ CPAP/ BiPAP
☐ Special needs: _____
_____
☐ Total Joint Replacement
☐ Shoulder
☐ Hip
☐ Knee
☐ Other:_____

**Current** medications (provide copy of list, if possible):
_____
_____
_____
_____
_____

**Recent** surgeries/ hospitalizations within the past **12 months**: _____
_____
_____

Name of **primary care physician**: _____
_____

Are there any **special accomodations** you need during your dental visits? If so, please specify.
_____
_____

**Women:** Are you ☐ pregnant? ☐ Breastfeeding? ☐ Taking oral contraceptives? ☐ N/A

**This form was completed by:** ☐ Patient ☐ Parent ☐ Guardian ☐ Caregiver ☐ Power of Attorney ☐ Translator

_____ _____
**Signature of patient or responsible party** **Today's Date**

_____ _____
**Signature of provider** **Today's Date**

Oneco Smiles, General and Cosmetic Dentistry ~ Marni Hansill, DMD / Kara Wells, RDH ~ 1612 53rd Ave E, Bradenton, FL 34203 ~ (941)758-3999 ~
onecosmilesfl@gmail.com ~ www.onecosmilesfl.com

ONECO SMILES
General and Cosmetic Dentistry

# FINANCIAL POLICY

I hereby agree to be responsible for the costs of care provided by Oneco Smiles General and Cosmetic Dentistry, for myself and/or my dependent(s). This includes any deductibles and/or amounts not covered, or paid by my insurance. **I also understand that it is my responsibility to be aware of the benefits and limitations outlined within my insurance policy.**

**I understand** there will be a $50 charge to all accounts in which a check payment is returned.

**I understand** because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. ***If I miss/cancel more that 2 appointments, within a calendar year, without giving at least 48 hours notice, I will be required to pay a $50 fee prior to being rescheduled for the missed appointment.***

***I understand when scheduling appointments, a deposit will be required for any treatment that requires more than one hour to complete.*** *The amount of the deposit will be equal to 20% of my estimated out-of-pocket expense, for the treatment which I am scheduling for, and it will be applied towards my total estimated out-of-pocket costs, once treatment has been completed.* ***If I do not show up for my appointment, or if I do not give at least 48 hours notice, that I am unable to keep my appointment, a portion of my deposit will be forfeited.***

***I understand for appointments which are scheduled for one hour or less, a cancellation fee may apply, if I do not provide at least 48 hours notice prior to cancelling*** *my scheduled appointment time.*

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to make last minute changes to your appointments.

**For treatment that is completed in one appointment**, I understand that payment is due in full at the time of service. **For treatment that requires multiple appointments to complete**, I will be afforded the option of making equal payments, at each corresponding appointment, ensuring that the treatment is paid in full at the time the treatment is completed.

I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency, once the past due balance has reached 90 days outstanding. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

**Date:**_____ **Signature:**_____

**For Insurance Patients Only:**

**Assignment of Benefits and Release:**

I, the undersigned, have insurance with _____, and assign benefits directly to Oneco Smiles General and Cosmetic Dentistry, all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

**Date:** _____ **Signature:**_____

ONECO SMILES
General and Cosmetic Dentistry

# HIPAA Compliance Patient Consent Form

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. 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 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.

Patient Name:_____
(Print First and Last Name)

| | | |
|---|---|---|
| May we phone, email or send a text to you to confirm appointments? | YES | NO |
| May we leave a message on your answering machine at home or on your cell phone? | YES | NO |
| May we discuss your dental conditions with any member of your family? | YES | NO |

If YES, please name the family members allowed:

_____

Patient Signature:_____ Date:_____


~ Oneco Smiles General and Cosmetic Dentistry ~ 1612 53rd Ave East Bradenton, Fl. 34203 ~ (941)758-3999 ~
OnecoSmilesfl@gmail.com

# DENTAL RECORDS RELEASE FORM

Patient's Name: _____ Date of Birth: _____

Phone Number: _____

Previous Dentist/Practice: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Myself
☐ Other Family:

Names of Family Members: _____

_____

I request and authorize you to release any and all of my dental information to Oneco Smiles General and Cosmetic Dentistry. Please forward my current x-rays with the dates that they were taken.

Patient Signature (Parent if a minor): _____ Date Signed: _____

**For digital x-rays, please email copies to OnecoSmilesFL@gmail.com**