Just Smiles
FAMILY AND COSMETIC DENTISTRY

NEW PATIENT ENROLLMENT FORM

We will need to gather some information in order to begin a new patient record. The information gathered below is strictly confidential and will be used for internal office use and insurance purposes only.

Today's Date: ____/___/____ Date of Birth: ____/___/____ Age:____

Last Name: _____ First Name: _____ MI: _____

Please check: Male ☐ Female ☐ SSN: _____

Spouse Name: _____ Date of Birth: ____/___/____ SSN: _____

Mailing Address: _____
Street City Zip

Phone numbers: Home:_____
Work: _____
Cell: _____

Email address: _____

Patient's Employer: _____

Spouse's Employer: _____

☐ Please check this box if you would allow us to send appointment reminders via **text message** in the future.

☐ Please check this box if you would allow us to send appointment reminders and messages about your dental care via **email**. We assure your confidentiality and your address will remain secure within our practice and not be shared with any third party.

Emergency Contact: _____ Phone number: _____

How did you hear about us? Please check all that apply:

Friend or Family ☐ Name: _____, Insurance company ☐, Website ☐, Google ☐

Drive By/Sign ☐, Yellow Book ☐, Mailing ☐, Newspaper Ad ☐, Other ☐: _____

If you have dental insurance, please provide all pertinent information to our front office personnel for verification. Just Smiles accepts most dental plans and we are preferred providers for many companies.

Remember, your dental insurance is a contract between your employer and the dental insurance company. It is ultimately your responsibility to know the details of your plan.
We will always help you with any questions you may have.

ASSIGNMENT AND RELEASE OF BENEFITS

I, the undersigned certify that I (or my dependent) have insurance coverage through _____ and assign benefits directly to Just Smiles for services rendered. I understand that I am financially responsible for **all charges** whether or not paid by my insurance. I hereby authorize Just Smiles to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Relationship Date

PLEASE TURN THE PAGE, READ AND COMPLETE THE OTHER SIDE

JUST SMILES PRACTICE STANDARDS

Treatment

We pride our selves in offering the highest quality of care possible. Our doctors do not allow insurance companies to dictate the course of a patient's treatment. We are a full service mercury free practice, we do not place any silver amalgam fillings but rather only place composite "white" fillings or porcelain restorations.

Appointments

We realize that our patient's time is valuable; therefore, we make every effort possible to minimize or eliminate the wait. We reserve time specifically for each patient and we will do everything in our power to get our patients in and out on time. We request the same courtesy from our patients.

If you find it impossible to keep an appointment, please call our office at least 48 hours in advance.

Appointments not cancelled within 24 hours and multiple cancelled or no show appointments will be, at our discretion, charged a $50.00 fee. Also, multiple cancelled appointments will not be rescheduled and patients will be placed on a strict last minute availability for any appointment.

Financial Responsibility

- Patient portion is always due on the day of service unless alternative financial arrangements have been made.
- We offer many payment options to allow your treatment to be comfortable and affordable. Please ask us about our payment plans when scheduling treatment.
- Payments extending beyond 30 days from the first billing will accrue interest at the rate of 1.5% per month on the unpaid balance (18% annual rate).
- There is a $25.00 charge for all returned checks (NSF).
- In the event of default, I promise to pay legal interest on the indebtedness, collection costs and related legal fees.
- We take pride in our knowledge and make every attempt to gain access to all dental plan information. The final balance owed is always dependent upon the benefit processed by your insurance. **You are responsible for any amount not covered by your insurance.**

PLEASE SIGN BELOW INDICATING YOUR ACCEPTANCE OF THE PRACTICE STANDARDS:

- I have read and I understand the Just Smiles Practice Standards
- I acknowledge that, upon request, I will be provided with a copy of the HIPPA privacy practices,
- I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to anonymously use my photographs for in-office patient education.
- I will be given the opportunity to discuss my treatment plan with the doctor and financial arrangements will be agreed upon before commencing treatment.

_____ _____

Signature of responsible party Date