T: (305) 361-8695 F: (305) 907-3002
info@kbmiles.com

**Welcome to our practice!**

Please fill out the enclosed documents. You may choose to fax or email them back to us prior to your appointment or you may bring them with you to your appointment in order to expedite your check in process.

-Patient's full Name: _____ Today's Date:_____

Nickname: _____ Date of Birth: _____/_____/_____

Street Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____-_____-_____ Marital Status: _____

Email address: _____

Cell Phone: _____ Alternative phone: _____

Occupation: _____ Employer: _____

Employer's Full Address: _____

Primary Doctor Name: _____ Phone: _____

**INSURANCE**

Do you have dental insurance? Yes No **If yes, please answer the questions below. If no, please skip section.**

Insurance Company: _____ Phone: _____

Insurance Address: _____

Member ID: _____ Group number: _____

Primary policy holder: _____ DOB: _____

Social Security Number: _____-_____-_____Relationship to patient: _____

Home Phone: _____ Employer: _____

**Person responsible for this account (please state "self" if applicable):**

Relationship to patient:_____ Cell phone: _____

Full Address: _____

**How did you hear about us**? If a Patient referred you, please provide their name:_____

Otherwise circle below:

Internet Google Yelp Zoc Doc Insurance Company Office Website Facebook Walked by

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## MEDICAL HISTORY

**Sex**: Male___ Female___

If female, please answer the following:

Are you taking Birth Control Pills? Yes No

Are you pregnant? Yes No lf yes, number of weeks? _____

Are you nursing? Yes No

**Height**: _____ **Weight**: _____ **Do you smoke or use tobacco?** Yes No How often? _____

**Please circle the conditions that apply to your medical history**

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| | | |
|---|---|---|
| Glaucoma | Thyroid problems | Drug abuse |
| High Blood Pressure | Tuberculosis | Emphysema |
| Pace Maker | Ulcers | Epilepsy |
| Pneumocystis | Venereal disease | Fainting Spells |
| Kidney Problems | Yellow Jaundice | Fever Blisters |
| Radiation Therapy | Abnormal bleeding | Frequent Headaches |
| Rheumatic Fever | Alcohol Abuse | Other: _____ |
| HIV+A\|DS | Allergies | |
| Liver Disease | Anemia | |
| Hay Fever | Angina pectoris | |
| Heart Attack | Arthritis | |
| Heart Surgery | Artificial Bones | |
| Mitral Valve Prolapse | Artificial Heart Valve | |
| Psychiatric Problems | Asthma | |
| Hemophilia | Blood transfusion | |
| Hepatitis A B C | Cancer | |
| Low Blood Pressure | Chemotherapy | |
| Seizures | Colitis | |
| Shingles | Congenital Heart Defect | |
| Sickle Cell Anemia | Cosmetic Surgery | |
| Sinus Problems | Diabetes | |
| Stroke | Difficulty Breathing | |

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## ALLERGIES

Please circle any that apply

Latex Penicillin Aspirin Sulfa Tetracycline Metals

slsaubidet@yahoo.com

Please write down all the Medications that you are currently taking:

_____

_____

_____

**Preferred Pharmacy:** What is your preferred pharmacy for future medications/prescriptions?

Name: _____

Address: _____ Phone Number: _____

**Emergency Contact: _____ Phone: _____**

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I WILL LET MY DOCTOR KNOW IF THERE ARE ANY KNOWN CHANGES IN MY MEDICAL HISTORY.**

**PATIENT/ GUARDIAN SIGNATURE _____ DATE: _____**

## DENTAL HISTORY

1. Purpose of initial visit _____
2. Are you aware of a problem? Explain _____
3. How long since your last dental visit? _____
4. Previous Dentist name and address _____
5. When was the last time you had dental x rays taken? _____
6. Are you unhappy with the appearance of your teeth? YES NO

If yes, explain_____

7. Have you lost any teeth or have any teeth been removed? YES NO

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If yes, why? _____

8. Have you had any problems or complications with previous dental treatment? YES NO

If yes, explain: _____

9. Do you clench or grind your teeth? YES NO 10. Does your jaw click or pop? YES NO

11. Have you experienced any pain or soreness in the muscles of your face or around your ear? YES NO

12. Do you have frequent headaches, neck aches or shoulder aches? YES NO

13. Does food get caught in your teeth? YES NO

14. Are any of your teeth sensitive to: HOT COLD SWEETS PRESSURE

15. Do your gums bleed or hurt? YES NO If yes, when? _____

16. How often do you brush your teeth? _____

17. Do you use dental floss? YES NO If yes, how often? _____

18. Are any of your teeth loose, tipped, or chipped? YES NO

19. Do you feel your breath is offensive at times? YES NO

20. Have you ever had gum treatment or surgery? YES NO If yes, when?

_____

21. Have you had any orthodontic work? YES NO

22. Describe any unpleasant dental experiences or anything about dentistry that you strongly dislike:

_____

23. Please rate your smile from 1 to 10_____

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.**

**PATIENT'S / GUARDIAN'S**

**SIGNATURE_____ Date: _____**

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# 24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, KB Smiles reserves the right to charge a fee for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a **24-hour advance notice.**

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

## Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

| **Credit Card Information** | |
|---|---|
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX<br>☐ Other _____ | |
| Cardholder Name (as shown on card): _____ | |
| Card Number: _____ | CVV CODE: |
| Expiration Date (mm/yy): _____ | |
| Cardholder ZIP Code (from credit card billing address): _____ | |

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

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# Patient Financial Agreement

**PLEASE READ THOROUGHLY AND SIGN BELOW**

## Upon receiving service from KB Smiles, you agree:

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing department. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.
- We will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable length of time (within 90 days), you may be responsible.
- All services provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. KNOW YOU BENEFITS.
- Upon check-out, we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check, and credit card of Master Card, Visa, Discover, American Express, and Care Credit.
- If your account is more than 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, it may be sent to a collection agency. If an account is sent to collections, it is the policy of this office to refrain from providing further medical care until the balance is paid in full.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account. Thank You for understanding our financial policy. Please let us know if you any questions or concerns.

**I have read and understood the financial policy and agree to abide by its guidelines.**

**X**_____ **Date:**_____

**PRINT NAME OF PATIENT OR RESPOSIBLE PARTY**

**X**_____

**SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

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# HIPPA

HIPAA Release of information AUTHORIZATION FORM I, hereby authorize KB Smiles and its affiliates, its employees and agents (collectively to release to KB Smiles my personal health information maintained (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me: _____ [DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of 5 years from the date or the date my coverage ends. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice.

I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. Legal Representatives sign below: By signing this form,

I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Patient Name ( Print) _____

Patient Signature_____ Date_____