PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

Sienna Smiles
OFFICE PRACTICES

WELCOME! Thank you for choosing our office! We are delighted to meet you and we hope your visit to our office will be the best dental experience you've ever had. Please help us in providing excellent customer service by carefully reviewing each page in this packet, and answering all questions to the best of your knowledge. If you have any questions or concerns, please do not hesitate to ask.

DENTAL INSURANCE:
We try our best to verify your insurance benefits as accurately as possible. The information we receive from your insurance provider prior to your appointment is only an ***estimate***. Insurance usually covers 20%-50% of the total charges after the deductible has been met. The exception to this policy is if a written predetermination can be received in our office prior to treatment. It can take up to 2-6 weeks to receive a written predetermination and even that is not a 100% guarantee of coverage.

Any outstanding amount not paid by the insurance company is due no later than 30 days after insurance payment. A statement will be mailed to the policy holder or designated responsible party specifying any credit or debit balances on your account.

PAYMENT FOR SERVICE:
Payment for any treatment and care rendered to you is due upon arrival for services. Our office accepts, cash, Visa and MasterCard. Checks are accepted at the discretion of the office. There is a $35 fee for insufficient funds.

CANCELLATION POLICY:
At Sienna Smiles, we are aware that in life things happen, and we understand emergencies. However, our schedule does not allow for a patient who repeatedly cancels appointments. Therefore:

_____We track all cancellations without a 48 hour notice.

_____ We will charge your a $50 late cancellation fee ***and*** require prepayment for any future appointments.

_____We also offer stand-by appointments for those who are unable to commit to a set appointment time. We will contact you with an appointment when we have an opening or change in the schedule. This works well for our patients who can't predict their schedule.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION
I hereby authorize insurance payment directly to Dr. Sakeena for benefits otherwise payable to me. I understand that I am financially responsible to Dr. Sakeena for the allowed charges not covered by this agreement. Dr. Sakeena is authorized to provide any insurance company(s), claim administrator(s), and consulting healthcare professionals with information concerning my healthcare, treatment, or supplies provided. This information will be used for the purposes of evaluation and administering claims for benefits.

I know that I have the right to receive a copy of this authorization on request and understand it will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Patient Signature_____**Date**_____

Witness Signature_____ **Date**_____

Sienna Smiles

AGREEMENT TO RECEIVE PROFESSIONAL SERVICES

I _____ will have the opportunity to discuss the ***estimated*** **cost of my treatment** with a Sienna Smiles staff member prior to treatment.

_____ I understand that any services provided will be based on the estimated cost of my dental treatment.

_____ I understand that during the course of my treatment, X-rays may be required to monitor changes and track my dental health.

_____ I understand that my dental insurance company may not pay for tooth colored fillings and I am responsible for the difference of cost between silver fillings (amalgam) and tooth colored fillings (composite).

_____ I will have the opportunity to ask questions regarding my dental treatment and any associated fees.

_____ I understand that I am responsible for the full amount of any dental treatment that my insurance does not cover.

_____ I understand that I am responsible for notifying the office of changes in insurance, prior to receiving any dental treatment.

_____ I understand that an appointment with Dr. Sakeena or her staff may be reserved for me. If for any reason I need to cancel this appointment I must provide 48 hours advance notice to the office during business hours. If less than 48 hours notice is given, there will be a $50 late cancellation fee charged to my account. Future visits may also require pre-payment.

_____ Sienna Smiles will provide me with an estimate of treatment costs; however fees for any services provided are the responsibility of the patient and/or responsibility party, regardless of the estimated insurance amount. If the insurance company does not begin to process my claim within 30 days, the balance will automatically become my responsibility. If there is a change in insurance and I fail to inform the office prior to treatment, I will be financially responsible for any services provided.

Sienna Smiles is pleased to offer financial arrangements for any treatment.

_____ _____

Patient Name Birth date

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____Date of Birth: _____

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Sienna Smiles; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____
Signature of patient or parent/legal guardian/legally responsible person

_____
Date

_____
Description of relationship to patient

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

- o Patient/personal representative refused to sign form
- o Other _____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:

- o Form mailed/sent to patient/personal representative on (date): _____

Part 3. Complete if either Part 1 or Part 2 completed:

_____ _____
Signature of staff member Date

Sienna Smiles

Welcome to Sienna Smiles! We are so pleased that you have chosen our office to take care of your dental needs. We would like to get to know you a little better, so, in order for us to best serve you, please take a moment and answer the following questions about your past experiences with dental care.

How would you rate the condition of your mouth?

☐Excellent ☐Good ☐Fair ☐Poor

Date of Last Dental Exam: _____ Date of Last Dental Treatment: _____

How often do you have dental examinations? Every 6 mo 1 yr 3 yrs If something hurts

What is your immediate concern? _____

_____

Please answer Yes or No to the following questions:

Are you Fearful of Dental Treatment? If so How much 1 (Least) to 10 (Most) _____	Yes	No
Have you had an unfavorable dental experience?	☐	☐
Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
Is there anything about the appearance of your teeth that you would like to change?	☐	☐
Are you uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
Have you been disappointed with the appearance of previous dental work?	☐	☐
Did you ever have braces, orthodontic treatment, or had your bite adjusted?	☐	☐
Have you ever had any teeth removed?	☐	☐
Do you have pain, sound, limited opening, locking, or popping of your jaw?	☐	☐
Do you have problems chewing gum, bagels, protein bars or any other hard foods?	☐	☐
Have your teeth changed in the last 5 years (become shorter, thinner, spaced)?	☐	☐
Are your teeth crowding or developing spaces?	☐	☐
Do you chew ice, bite your nails, use your teeth to hold objects, or have other habits?	☐	☐
Do you clench your teeth in the daytime, and find that your jaws are sore?	☐	☐
Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
Do you wear or have you ever worn a bite appliance?	☐	☐
Have you had any cavities in the past 3 years?	☐	☐
Do you have dry mouth or difficulty swallowing foods?	☐	☐
Do you feel or notice any holes on the biting surface of your teeth?	☐	☐
Do you have grooves or notches on your teeth near the gumline?	☐	☐
Have you ever had broken teeth, chipped teeth, or a toothache or cracked filling?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐
Have you been treated for gum disease or been told you have lost bone.	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐

How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know?

_____

_____