Southern Smiles
FAMILY AND COSMETIC DENTISTRY
DR. ALEX KREMPA DMD 344-0230

AGREEMENT

ABOUT YOU

Today's date: _____

Name: _____ Birth date: ____/____/____

Address: _____ Apt No: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell/Work phone: _____

E-mail address: _____ ☐ Female ☐ Male

Social Security # _____ Marital status: ☐ Single ☐ Married ☐ Widowed

Occupation/Employer_____

Name of spouse and children: _____

How did you hear about us: Facebook Google search Review sites Internet search Magazine Print
(circle all that apply) Insurance list Friend Family Coworker Mailer Saw sign Other: _____

Whom may we thank for referring you: _____

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____Phone:_____

INSURANCE INFORMATION

Insurance company name: _____

Group#: _____ ID/Social Security#: _____

Policy Holder's name: _____ Holder's birth date: ____/_____/_____
Holder's employer: _____ Holder's SS#: _____

Do you have another policy: Y N

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of two business days.** We understand that conflicts arise; however, failing your appointment or canceling without adequate notice more than once will result in a $50 charge. Initials:_____

MEDICAL HISTORY

Name of personal physician:_____ Approximate date of last visit:_____

Current health condition: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any serious health problems in the last 5 years? ☐ Yes ☐ No If yes, please explain:

_____

(For women) Are your currently pregnant or nursing? ☐ yes ☐ no If yes, how many months? _____

Please list any past surgeries:_____

Please list prescription medications:_____

Please list vitamin/herbal supplements:_____

Do you use tobacco or alcohol? ☐ Yes ☐ No (If yes, how often?) _____

Please check if you're allergic to any of the following:

☐ Local anesthetics ☐ Sulfa drugs ☐ Codeine/other narcotics ☐ Barbiturates, sedatives, sleeping pills
☐ Aspirin ☐ Latex sensitivity ☐ Penicillin/other antibiotics ☐ Shellfish, iodine or red wine
☐ Other_____

Do you have, or have you had, any of the following?

☐ Abnormal Bleeding
☐ Artificial Heart Valve
☐ Blood Disease
☐ Chemotherapy
☐ Convulsions
☐ Emphysema
☐ Fainting Spells/Dizziness
☐ Heart Attack/Failure
☐ Hepatitis
☐ Liver Disease
☐ Lupus
☐ Rheumatic Fever
☐ Stroke
☐ AIDS/HIV Positive
☐ Artificial Joint
☐ Breathing Problem
☐ Chest Pains
☐ Diabetes
☐ Epilepsy or Seizures
☐ Frequent Cough
☐ Heart Pace Maker
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Psychiatric Care
☐ Rheumatism
☐ Thyroid Disease
☐ Anemia
☐ Asthma
☐ Cancer
☐ Congenital Heart Disorder
☐ Easily Winded
☐ Excessive Bleeding
☐ Frequent Headaches
☐ Hemophilia
☐ Kidney Problems
☐ Lung Disease
☐ Radiation Treatments
☐ Stomach/Intestinal Disease
☐ Tuberculosis

Have you ever had any serious illness not listed above? If yes, please explain: _____

DENTAL HISTORY

Do you have dental examinations and cleanings on a routine basis? Y N
Date of last dental cleaning/x-rays ? _____
Who was your previous dentist? _____
How could we improve from your last visit? _____

Generally, how have you felt about your previous dental appointments?
Very anxious and afraid Somewhat anxious and afraid Don't care one way or the other Look forward to it

Do your gums bleed when you brush? Y N Is your toothbrush: Manual or electric Do you floss? Y N
Are your teeth sensitive? Y N If so, to which of the following? Cold Hot Sweets Pressure

Have you had a serious/difficult problem associated with any previous dental treatment? Yes or No
If yes, explain:

How do you feel about the appearance of your teeth? _____
Which of the following is **MOST** important to you in a dental setting?
Highest quality Lowest Price Convenient hours Pain free On Time Appointment

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CONSENT FOR TREATMENT

I, _____, hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks such as permanent numbness.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimal amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I understand that outcomes cannot be guaranteed in dentistry and that there are risks and complications to any procedure.

_____ _____
{Signature} {Date}

_____
{Guardian's signature}

FEE FOR LABORATORY BILL

I agree to pay the costs to cover my lab bill that are required to deliver excellent health care by Dr. Martin and Dr. Krempa. Our doctors believe in using materials made in the USA and of the highest quality to ensure the best possible result. I understand that most insurance companies will not provide a benefit for my lab bill.

_____
{Signature}

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
{Signature} {Date}

☐ Individual refused to sign

FINANCIAL ARRANGEMENTS

Payment is due at the time services are rendered. All major credit cards, cash and personal checks are accepted. If an extended payment plan is desired, please ask us about financing programs available. If required, I also understand a check of my credit history may be made. If you have any questions, please do not hesitate to ask.

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorneys' fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.596 per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added (33%).

If you have dental Insurance

As a courtesy, we accept payment from most insurance companies and will file your claim on your behalf. We will estimate your deductible, copayment and any portion not covered by your insurance company's policy. As this is an estimate, the amount due to our office may be adjusted accordingly after an insurance claim is processed. Any insurance claims that remain unpaid will become due and payable by you.

By signing below, I acknowledge that all services rendered will be charged directly to me and I am ultimately responsible for my account regardless of my insurance benefits.

_____ _____

{Signature} {Date}

OFFICE POLICIES AND BINDING ARBITRATION AGREEMENT

I agree to be responsible for all charges for services and materials not paid by a benefit plan. I authorize release of information relating to any claim filed on my behalf. I also authorize payment of benefits to be paid directly to Southern Smiles, PC (SSPC). I authorize SSPC to contact me via email, cell and/or text. At SSPC's sole election, any controversy or claim arising out of or relating to this Agreement or the services provided hereunder not resolved by good faith efforts to settle shall be decided by a single arbitrator of SSPC's choosing which arbitration shall be administered in accordance with the Arbitration Rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

_____ _____

{Signature} {Date}