Smiles with Care
Dr. Nancy Bouchard

CHILD REGISTRATION

Patient Information

First Name_____ Last Name _____Middle Initial ___

Nickname _____ Birth date _____ Male Female

Address _____

City, State, Zip _____

Mother's Information Stepmother Responsible for Finances

Name _____ Birth date _____

Address _____

Email Address _____

PHONE: Home _____ Work _____Cell _____

Father's Information Stepfather Responsible for Finances

Name _____ Birth date _____

Address _____

Email Address _____

PHONE: Home _____ Work _____Cell _____

WHO IS / ARE THE LEGAL GUARDIAN(S) OF THIS PATIENT? _____

Primary Insurance

Policy Holder _____ Relationship to Patient _____

Holder's Social Security Number _____ Birth date _____

Employer _____ Address

Insurance Company _____ Insurance Phone _____

Secondary Insurance

Policy Holder _____ Relationship to Patient _____

Holder's Social Security Number _____ Birth date _____

Employer _____ Address _____

Insurance Company _____ Insurance Phone _____

How did you hear about our practice?

_____

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PATIENT REGISTRATION

Patient Information

First Name_____ **Last Name** _____ **Middle Initial** ___

Nickname _____ **Birth date** _____

Address _____

City, State, Zip _____

Email Address _____

PHONE: Cell _____ **Home** _____ **Work** _____

Social Security Number _____

How would you prefer us to contact you? Home Work Cell Email Text

Marital Status: M S D Sep W // Employment: Full Part Retired

NAME OF PERSON RESPONSIBLE FOR PAYMENT _____

In case of emergency, please contact _____ **Phone** _____

Primary Insurance

Policy Holder _____ **Relationship to Patient** _____

Holder's Social Security Number _____ **Birth date** _____

Employer _____ **Address**

Insurance Company _____

Secondary Insurance

Policy Holder _____ **Relationship to Patient** _____

Holder's Social Security Number _____ **Birth date** _____

Employer _____ **Address** _____

Insurance Company _____

Please Provide Your Dental Insurance Card and Dental Insurance Cards

How did you hear about our practice?

_____

Do you live in FL all year? YES NO
If not, what months are you here? _____

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MEDICAL HISTORY

Physician _____ **Office Phone** _____

Please explain any medical conditions, hospitalizations, or operations

_____

What is your preferred pharmacy? _____

Are you allergic to or have you had any reactions to

Aspirin **Penicillin** **Codeine** **Local Anesthesia**
Acrylic **Metal** **Latex**
Other _____

WOMEN
Are you pregnant? YES NO
Are you nursing? YES NO

Have you used tobacco or controlled substances? Yes No

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

	YES	NO		YES	NO		YES	NO
ADD / ADHD	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐
AIDS/HIV	☐	☐	Emphysema/COPD	☐	☐	Radiation Therapy	☐	☐
Angina	☐	☐	Epilepsy/Seizures	☐	☐	Shingles	☐	☐
Alzheimer's /Dementia	☐	☐	Excessive Bleeding	☐	☐	Sinus Troubles / Allergies	☐	☐
Anxiety /Depression	☐	☐	Heart Attack /Troubles	☐	☐	Stomach intestinal Problems	☐	☐
Arthritis	☐	☐	Heart Pace Maker	☐	☐	Thyroid Problems	☐	☐
Artificial Heart Valve	☐	☐	Hemophilia	☐	☐	Tuberculosis	☐	☐
Artificial Joints	☐	☐	Hepatitis	☐	☐	Tumors	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Ulcers		
Cancer	☐	☐	Kidney Disease	☐	☐			
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐			

Please list any medications you are taking.

_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or to the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Patient / Parent / Guardian **Date**

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DENTAL HISTORY

Name of Previous Dentist _____

Date of Last Exam _____

	YES	NO
Are you experiencing any pain?	☐	☐
What causes the pain? _____		
Are your teeth sensitive?	☐	☐
If so, to what? _____		
Do your gums bleed while brushing or flossing?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Where? _____		
Do you wear dentures or partials?	☐	☐
Have you had any trouble with your jaw?	☐	☐
If so, what? _____		
Do you clench or grind your teeth?	☐	☐
Have you had difficult extractions?	☐	☐
What happened? _____		
Do you like your smile?	☐	☐
If not, why? _____		

Consent for shared Information with your dentist back home

We understand that Snow Birds and Visitors to Fort Myers Beach have dentists back home. If you wish, we will make every effort to communicate with your dentist to share x-rays and other information pertinent to your care.

I _____ **give Dr. Nancy Bouchard permission to**
(Print Name)

☐ **Send x-rays and other dental information regarding my care to**

☐ **Request x-rays and other pertinent dental information from**

_____
Dentist

_____
City/State **Phone**

_____
Email

_____
Signature **Date**

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Please initial each section and sign at the end.

_____ Consent for Dental Treatment

I authorize the dental professionals (dentists, hygienists, and assistants at Smiles With Care to provide dental treatment for me and my dependents. I understand that dental treatment has some risks and that there are no guarantees regarding the results of treatment. Should complications occur, I understand that other procedures may be necessary. I understand that there are often alternative treatments available.

_____ Insurance

We participate with numerous insurance plans and will comply with all insurance regulations. <u>It is important to understand that insurance is designed to reduce your cost; not to eliminate fees.</u> Insured patients must read their policies carefully to become familiar with its benefits and limitations. Should your insurance require a pre-authorization prior to treatment, please advise us.
<u>You are ultimately responsible for the full amount of your bill regardless of your insurance coverage.</u>

_____ Payment

I accept full financial responsibility for me and my dependents.

An estimate of your financial portion will be collected at the time of service. For your convenience we accept cash, checks, Visa, MasterCard, Discover, and Care Credit.

_____ Returned Checks

Any checks returned are subject to a $25 fee. Immediate remittance in the form of cash, money order, or certified funds is expected.

_____ Overdue Accounts

Overdue accounts more than 60 days will incur late fees at 24% per year. If the account is not cleared within 90 days, the account will be turned over to our collections service, and you will be responsible for all fees charged by the collection agency.

_____ Assignment of Insurance Benefits

I assign to Dr. Nancy E Bouchard, DDS all benefits/payments for dental services rendered to me and/or my dependents

_____ Missed Appointments

There will be a fee for failed and cancelled appointments without 24 hours prior notice. Missed appointment fees are

- **$25 per half hour for hygiene appointments**
- **$50 per half hour for dental appointments**

_____ Authorization for Disclosure of Health Information

I hereby give my permission for the use of my dental information for purposes of

_____Professional consultations, research, law enforcement, and payment.

_____This includes permission to Dr. Nancy Bouchard to use any x-rays or photos in continuing education courses and blogs. My name can/will be hidden.

_____This includes permission to Dr. Nancy Bouchard to use x-rays or photos on her Facebook and web page. My name can/will be hidden.

_____ Acknowledgement of Receipt of Privacy Practices

I have been given an opportunity to read the office's Notice of Privacy Practices. If I wish, I can obtain a hard copy for my records.

I have had the opportunity to read this form, ask questions, and have had my questions answered to my satisfaction.

I have the right to revoke my consent to treatment and my disclosure of health information.

I have the right to a copy of this form.

_____

Print Name of Patient **Date**

_____

Print Name of Person Financially Responsible / Parent / Guardian

_____

Signature of Person Financially Responsible / Parent / Guardian

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Patient Rights and Responsibilities Form

Patients have the right:

1. To be treated humanely, with dignity, and respect.
2. To not be discriminated against due to race, religion, ethnicity, sexual orientation, or disability or health condition.
3. To receive treatment appropriate to your dental condition.
4. To have diagnosis and treatment explained in understandable terms.
5. To participate in the formulation and revision of the treatment plan.
6. To refuse treatment, request another dentist or hygienist, or seek a referral outside of the practice.
7. To access your dental record as deemed appropriate by the dentist or hygienist.
8. To receive services that adhere to the principles of confidentiality and privacy except for the following specialized circumstances:
    a. When circumstances place the patient's welfare or that of others in immediate danger.
    b. When disclosures made by the patient raises the suspicion of child physical, mental, or sexual abuse or neglect, or if an adult discloses an allegation of abuse in their childhood. In this situation, the law requires a report be made to the appropriate agency, usually Social Services.
    c. When a court order requires testimony or release of patient's records.
    d. In a circumstance where the dentist or hygienist determines that consultation within the practice is needed in order to provide optimal treatment, in which case the utmost discretion will be used to insure privacy.

Patients have the responsibility:

1. To know the benefits and exclusions of your insurance coverage and to provide us with current insurance information.
2. To make regular and prompt payments for services rendered.
3. To keep scheduled appointments. Patients will be charged for missed appointments or cancellations for which 24 hour notice has not been given.
4. To follow the mutually agreed upon treatment plan.
5. To be open and honest in sessions.
6. To report any safety concerns or abuse allegations to your dentist or hygienist.
7. To discuss with your dentist or hygienist any concerns about treatment, including the desire to terminate treatment.

Print Name of Patient / Parent / Guardian

Signature