Paige Prather Smiles

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Please complete this paperwork at least 2 days prior to your appointment.
Please only use dashes (-) when entering phone numbers.

Chart#: ______________
FOR OFFICE USE ONLY

Patient Name: ______________ * Last ______________ * First ____ MI

______________ Preferred Name

Title: * ______________ Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: * ______________

SS#: ___-__-____

Prev. Visit: ______________

Email Address: ______________

Best time to call: ______________

Phone: ______________ * Home ______________ Mobile ______________ Work ______ Ext

______________ Fax ______________ Other

Address: ______________ * Address 1

______________ Address 2

______________ * City ______ * State _____-____ * Zip Code

In case of emergency, who is to be notified? (Please provide best contact phone number)

____

____

We send appointment updates to notify you of an upcoming appt. 1 week and 1 day in advance. How do you prefer to receive these notifications? *

◯ Phone Call ◯ Text Msg ◯ Email

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________________

Phone: ______________

Employer Address: ______________________________
Address 1

____
Address 2

____
City

________ _____-____
State Zip Code

Dental Insurance Information

☐ *I authorize Dr. Paige M Prather, PLLC, to release any and all identifying health information that will be necessary in filing a claim with my dental insurance carrier. I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it.

Name of Insured:

Last

First

MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:

ID Number: (Located on Front of your insurance card, may also be labeled as Enrollee ID #, sometimes the same as your Social Security #) If none please state "none".

Social Security Number and Date of Birth of Insured (Policy Holder)

Insurance Provider Contact Phone Number (Located on Insurance Card):

Please verify that the information you have provided is correct. It is your responsiblity to provide us with accurate information about your insurance coverage. Failure to do so can result in delay of payment or declination of payment by your insurance and you will have to assume full responsibility for the cost of service.

Minor/Child Agreement:

☐ I understand that any parent, who brings in a minor for treatment, is responsible for that patient's account balance. A Guardian must remain in the office for the entire duration of a minor's treatment. No patient, under the age of 18, will be treated without a documented guardian present in the office. I verify that I am the parent/guardian of the said patient and there are no court orders now in effect that prohibit me from signing this form. I do hereby authorize the dental staff of Dr. Paige Prather to perform any necessary dental services for the stated minor. Should a child be "dropped off" or left without an attending guardian, the dependent's appointment will be cancelled and charges will apply.

Cancellation Policy

☐ * Your appointment time is especially reserved for you. We value your time and we ask that you value the time of our doctor and other patients. Having an accurate schedule allows our team to provide each patient with maximum attention and allows us to keep more closely to your scheduled appointment time. We pride ourselves on little to no wait time. A $75 cancellation fee will be applied for any appointment 1 hr. or less in length canceled without 2 business days notice. Down payments are required to schedule any appointment over 1 hour in length. These down payments are nonrefundable if cancelled without 2 business days notice for any reason at a rate of $250/hr. of reserved time. Cancellation of a sedation appointment will differ from this basic policy and these terms will be reviewed at the time of booking the appointment. If you arrive more than 15 minutes late you will be asked to reschedule your appt. out of consideration for our other patients' time and a cancellation fee will apply. If you cancel more than 2 times without 2 business days notice within a period of 6 months, you will be moved to our Priority Scheduling list, meaning appointments cannot be scheduled more than one day in advance of the appointment time. We provide complimentary reminders of your appointment via text, email, and phone calls. Most of our patients greatly appreciate this service. You may choose the reminder method that works best for you or opt out of this service entirely. However, all cancellation policies still apply. If you have questions or concerns about this policy, please consult with a team member prior to scheduling an appointment.

Financial Policy: Please read over thoroughly prior to receiving services.

☐ * Payment is due, in full, at the time of service. We can accept Cash, Mastercard, Visa, Discover, American Express, Care Credit and insurance checks. We accept personal checks from patients with a record of 6 months with our practice. We charge a service fee of $30.00 for any check that is returned.

☐ * As a courtesy for insured patients with the exception of infant and therapy patients, a dental claim is filed on the date services are received. For all infant and therapy patients a claim is provided to the patient prefilled with the codes so the patient can file for reimbursement from their insurance carrier. We collect in full upfront for all services provided. We do work with some third party financing companies should you need this option to help keep your dental health on track. Payment is usually remitted from your insurance carrier within 30 days of the service date. If at 30 days, your claim is still unpaid you may contact your insurance carrier directly to ensure timely payment of the claim. We can resubmit your claim if necessary for up to 60 days. At 60 days if the claim is still unpaid, you will need to pursue reimbursement on your own and can contact your carrier directly for help with this. If for any reason payment is not collected prior to services being renderedall outstanding balances are due an payable no later than 30 days after services are rendered. Failure to do so will result in late fees and finance charges at a rate of 8% of the total amount owed. Should extensive measures be required to collect any past due balance you agree to be responsible for all fees associated with such collection including but not limited to attorneys fees.
Insurance Policies have specified restrictions that limit a patient's treatment. If you choose to receive the services prescribed by Dr. Prather and they are not covered by your insurance, all costs associated with the non-covered services are your full financial responsibility. We always base treatment recommendation on what is best for you and your overall health, not on what insurance will cover. No guarantee or estimate can be given on your insurance coverage as this is an agreement and policy set up by your employer and your insurance carrier is liable to you only for these benefits.

☐ * HIPAA NOTICE: Notice of Privacy Practices: Effective Date of Notice: January 24, 2007. We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it. This Notice is available at any time, for your review or personal copy, in the reception area of our practice. By checking this box you are confirming knowledge of your rights to privacy as a patient and the receipt of this Notice.

☐ * By checking this box, I acknowledge that the information on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I/my minor have any changes in contact/personal information. I realize that failure to do so can result in inability to reach me and or provide products and or notifications reguarding my treatment and health and that additional costs may be incured because of this.

We will have you sign this paperwork electronically upon arrival to our office. Upon signing you are stating you understand and agree to comply with all policies as outlined in this document.

Signature ____________________

Date ____________________

Response Date: __________

PEDIATRIC/ADOLESCENT PATIENT HISTORY

Date of Birth: ______/______/______

Name of Mother: ___________________ **Name of Father**: ________________________

Delivery: ☐ Vaginal ☐ Cesarean **Was this child premature?** __________ How many weeks? __________

Were there problems with this child's delivery? ______ If so, please list: ____

Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc?

____

Did this child need special treatment while in the hospital such as oxygen, transfusions, or lights? _______________________________

Did/Does this child have any problems with breastfeeding or formula feeding? ________________________

____

Does this child suck a finger, thumb or pacifier? _____________

Does this child have any other oral fixations/habits? ____

Please mark all of the following that this child has been treated for:

☐ Heart Disease	☐ Bleeding/Transfusions	☐ Asthma/Trouble Breathing	☐ Mental Delays
☐ Liver/GI Disease	☐ Anemia	☐ Hepatitis	☐ Physical Delays
☐ Kidney Disease	☐ Rheumatic Fever	☐ Cleft Lip/Palate	☐ Adverse Drug Reactions
☐ Speech/Hearing	☐ Seizures	☐ Frequent Infections	☐ Autism
☐ Eyesight	☐ Congenital Birth Defects	☐ Endocrine/Growth	☐ Sensory Processing Disorder
☐ Cancer/Tumors	☐ Significant Injuries	☐ Blood Dyscrasias	❏ Apraxia
☐ Cerebral Palsy	☐ Diabetes	☐ AIDS	Other: __________________

Does this child have any of the following?

☐ Lung Problems	☐ Heart Problems	☐ Kidney/Urinary Problems	☐ Bone/Muscle Problems
☐ Gastro-Intestinal Problems	☐ Brain/Nervous System Problems	☐ Skin Problems	☐ Eye/Ear/Nose/Throat Problems

Has this child ever had a reaction to or problem with an anesthetic? Y N **Describe:** ____

Is this child up to date on immunizations against childhood diseases? Y N

Recent Hospitalizations or Surgeries: ____

Please list all known drug allergies: ____

Please list any regular medications (over the counter or prescription) and include dose and frequency: _________________________

____

Any other medical issues we should be aware of:____

Name of Pediatrician: ________________________ **Phone:** _______________________**Date of last physical exam:**__________________

To the best of my knowledge, this information is true and correct. I know if there are any changes in my child's health, it is my responsibility to inform my child's provider.

Print Patient Name: _________________________ **Relation**: _____________________________

Print Name of Parent/Guardian: ____ **Date**: ________________________________

Signature of Parent/Guardian: ____

Authorization for Release of Information to Providers

Patient Name: ____________________________ Date of Birth: _________________________

To provide patients with optimal care we try our best to work as a team with other providers and keep open lines of communication. Please list any other providers the patient is currently seeing including PCP, pediatrician, therapists, chiropractors, bodyworkers etc. This gives us permission to discuss care with them as needed and allows them to be supportive and provide optimal care as well.

I authorize PS Smiles to release my medical/dental and/or billing information to the following individual(s):

1. Name and phone number____

   Specialty: ____

2. Name and phone number____

   Specialty: ____

3. Name and phone number ____

   Specialty: ____

4. Name and phone number ____

   Specialty: ____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: ____ Date: ___________________________

Paige Prather
Smiles

Authorization for Release of Information to Family Members

Patient Name:_____________________________ Date of Birth:_________________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical/dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/dental or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Paige Prather Smiles to release my medical/dental and/or billing information to the following individual(s):

1.____________________________________ Relation to Patient:_______________________

2.____________________________________ Relation to Patient:_______________________

3.____________________________________ Relation to Patient _______________________

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:_____________________________________ Date:_________________________