Clear Smiles Dental

Welcome and thank you for choosing **Clear Smiles Dental**! We would like to take this opportunity to introduce you to our practice and to offer assistance in making your visit a comfortable one. The initial visit for an adult will take approximately 90 minutes. Please bring a photo ID and any insurance cards with you. The Federal Trade Commission now mandates that all adult patients present a valid photo ID in hopes of preventing identity theft.

New Patient Forms:

We will need a registration form, a medical history and a HIPPA form from you. These forms are enclosed. Please BRING COMPLETED FORMS with you to save time at your initial visit appointment.

Financial Policy:

Clear Smiles Dental will gladly file dental insurance claims for all of your visits to our office. It is not the responsibility of Clear Smiles Dental to know your insurance carrier benefits. If there is a deductible or co-payment due from you, it is expected at the time of service. After 90 days, any portions not paid by your insurance provider become your responsibility. We accept cash, check, debit card, credit card, or CareCredit.

Appointments and Cancellation Policy:

Clear Smiles Dental makes every attempt to schedule your appointments at times that are most convenient for you. We are open at 8:30am every morning and stay open late and we strive to stay on schedule. There may be times when our practice experiences delays because of emergencies or the discovery of a more serious problem that requires immediate attention. Rest assured that we are making every effort to honor your time and give you the attention you need.

Clear Smiles Dental asks that if you cannot keep your appointment time that you give us 24 hour notice of cancellation. In the event of a no show or same day cancellation, a $25.00 broken appointment fee may be assessed.

Treatment Estimates

Before any treatment is initiated, we consult with our patients to ensure there is full understanding of the need for treatment, the procedure by which treatment will be rendered, and the estimated cost of the treatment. Just as with any health condition, the discovery of a more substantial problem during a procedure can alter the recommended course of action. We will always keep you apprised of any changes necessary, your options in procedure, and how they affect the cost of treatment.

Thank you for choosing Clear Smiles Dental to take care of all your dental health care needs. We strive to be perceptive and sensitive to the feelings of our patients at all times; to be empathetic and sympathetic to their physical and emotional needs. Above all, we strive to give each patient the best quality dental care in every possible respect, constantly updating our knowledge and methodology.

We look forward to being your dentist and your friend.

The Team of Clear Smiles Dental

LOCATION
12177 Pembroke Road.
Pembroke Pines, FL 33025

PHONE NUMBERS
OFFICE (954) 505-3269
FAX (954) 589-0810

OFFICE HOURS
Monday - Friday
8:30 am to 5:30 pm

CLEAR SMILES DENTAL

Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in severe pain needing immediate care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 954-505-3269. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-Show Policy:

A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. "No-shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the physician. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show" there will be no charge to the patient. Any additional "noshows" will result in a fee of $25.00 for regular appointments and $50.00 for procedures. A credit card authorization form or $50 deposit will also be required prior to future appointments. If a patient accumulates 3 “No-shows”, he or she may be asked to leave the practice.

Cash Only:

If you are uncomfortable using a credit card, following your first “no-show” a $25.00 cash deposit will be required to schedule future appointments and a $50.00 cash deposit will be required prior to procedures. This amount will be applied to your bill on the day of the appointment and any remaining balance will be refunded at this time. No checks.

Late Cancellations:

Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee. I understand this policy and authorize Clear Smiles Dental to assess cancella-tion and no show fees according to the above outlined policy to the credit card listed below.

_____ _____ _____

Patient (or responsible financial party) | Date | Printed Patient Name

☐ VISA ☐ MasterCard _____ _____ / _____

Credit Card Information | Discovery Number | Expiration

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Clear Smiles Dental Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of the HIPAA's requirements, we are making available to you a copy of our Notice of Privacy Practices (copy available in our office). This notice contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Florida Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with : a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement/Consent

Please sign this form below to acknowledge that a copy of our notice of privacy practices has been made available to you and to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I acknowledge that a copy of the Notice of Privacy Practices has been made available to me (Copy available in our office). I also consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature (Parent sign, if minor)	Date	Patient Name (Please Print)

For office use only

Patient refused to sign. The following circumstances prohibited the patient from signing the Acknowledgement:

An emergency situation prevented the patient from signing the Acknowledgement.

Office Personnel (Signature)	Date	Office Personnel (Print Name)

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CLEAR SMILES DENTAL

Medical History

_____ / /

Patient Name | Birth Date

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

YES NO

- ☐ ☐ Are you under a physician's care now? If yes, please explain: _____
- ☐ ☐ Have you ever been hospitalized or had a major operation? If yes, please explain: _____
- ☐ ☐ Have you ever had a serious head or neck injury? If yes, please explain: _____
- ☐ ☐ Are you taking any medications, pills, or drugs? If yes, please explain: _____
- ☐ ☐ Do you take, or have you taken, Phen-Fen or Redux?
- ☐ ☐ Are you on a special diet?
- ☐ ☐ Do you use tobacco?
- ☐ ☐ Do you use controlled substances?
- ☐ ☐ Do you need to pre-medicate? If yes, please explain: _____
- ☐ ☐ (WOMEN) Are you Pregnant/Trying to get pregnant?
- ☐ ☐ (WOMEN) Taking oral contraceptives?
- ☐ ☐ (WOMEN) Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

Other, If yes, please explain: _____

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

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS/HIV Positive	☐	☐	Excessive Bleeding	☐	☐	Lung Disease
☐	☐	Alzheimer's Disease	☐	☐	Excessive Thirst Fainting	☐	☐	Mitral Valve Prolapse Pain
☐	☐	Anaphylaxis	☐	☐	Spells/Dizziness	☐	☐	in Jaw Joints Parathyroid
☐	☐	Anemia	☐	☐	Frequent Cough	☐	☐	Disease Psychiatric Care
☐	☐	Angina	☐	☐	Frequent Diarrhea	☐	☐	Radiation Treatments
☐	☐	Arthritis/Gout	☐	☐	Frequent Headaches	☐	☐	Recent Weight Loss Renal
☐	☐	Artificial Heart Valve	☐	☐	Genital Herpes	☐	☐	Dialysis
☐	☐	Artificial Joint	☐	☐	Glaucoma	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Hay Fever	☐	☐	Rheumatism
☐	☐	Blood Disease	☐	☐	Heart Attack/Failure	☐	☐	Scarlet Fever
☐	☐	Blood Transfusion	☐	☐	Heart Murmur	☐	☐	Shingles
☐	☐	Breathing Problem Bruise	☐	☐	Heart Pace Maker	☐	☐	Sickle Cell Disease
☐	☐	Easily	☐	☐	Heart Trouble/Disease	☐	☐	Sinus Trouble
☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Spina Bifida
☐	☐	Chemotherapy	☐	☐	Hepatitis A	☐	☐	Stomach/Intestinal
☐	☐	Chest Pains	☐	☐	Hepatitis B or C Herpes	☐	☐	Disease Stroke
☐	☐	Cold Sores/Fever Blisters	☐	☐	High Blood Pressure	☐	☐	Swelling of Limbs
☐	☐	Congenital Heart Disorder	☐	☐	Hives or Rash	☐	☐	Thyroid Disease
☐	☐	Convulsions	☐	☐	Hypoglycemia	☐	☐	Tonsillitis
☐	☐	Cortisone Medicine	☐	☐	Irregular Heartbeat	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Kidney Problems	☐	☐	Tumors or Growths
☐	☐	Drug Addiction	☐	☐	Leukemia	☐	☐	Ulcers
☐	☐	Easily Winded	☐	☐	Liver Disease	☐	☐	Venereal Disease
☐	☐	Emphysema	☐	☐	Low Blood Pressure	☐	☐	Yellow Jaundice
☐	☐	Epilepsy or Seizures	☐	☐		☐	☐	

Have you ever had any serious illness not listed above? Yes ☐ No ☐ If yes, please explain: _____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____ / /

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CLEAR SMILES DENTAL

Patient Registration

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

Preferred Name:_____ Patient is: ☐ Responsible Party ☐ licy Holder

Responsible Party: (if someone other than the patient)

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

Address:_____ Address 2:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

☐ Responsible Party is Policy Holder for Patient ☐ Primary Policy Holder ☐ Secondary Policy Holder

Patient Information:

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

Address:_____ Address 2:_____

City:_____ ate:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Can this # receive SMS/text messages ☐ Yes ☐ No

Sex: ☐ Female ☐ : ☐ Married ☐ Single ☐ Divorced ☐ Separeted ☐

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

Email:_____ ☐ I would like to receive email correspondences

Patient Information (Section 2):

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed

Student Status: ☐ Full Time ☐ Part Time

Preferred Dentist:_____ Preferred Hygienist:_____ Preferred Pharmacy:_____

Referred By:_____ Medicaid ID:_____

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Primary Insurance Information:

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information:

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____