Pewaukee Smiles
DENTISTRY

New Patient Registration

Welcome to our practice!

Last name: _____ First name: _____ Middle name: _____

Preferred name: _____ Title: _____ Gender: _____ DOB: _____

Marital status: _____ SSN: _____

Email address: _____ Mobile phone: _____

Address: _____ City, State: _____ Zip: _____

Emergency contact: _____ Phone: _____

Relationship to you: _____

Preferred pharmacy: _____

Employer information (if applicable)

Employer name: _____ Phone: _____

Who may we thank for referring you to our practice?

☐ Search engine
☐ Pewaukee Smiles Dentistry website
☐ Insurance provider
☐ Family/friend
☐ Specialist
☐ Other _____

If applicable, name of person/office who referred you:

_____

Responsible Party Information

this only needs to be filled out if the insurance subscriber is someone OTHER THAN the patient, such as a parent, guardian, or spouse. SKIP section if not applicable

Last name: _____ First name: _____ Middle name: _____

DOB: _____ SSN: _____ Relationship to patient: _____

Email address: _____ Mobile phone: _____

Address: _____ City, State: _____ Zip: _____

Primary Dental Insurance

SKIP section if you do not have dental insurance

Last name of subscriber: _____ First name of subscriber: _____

Subscriber's DOB: _____ Subscriber's employer name: _____

Insurance plan name: _____

Subscriber or Member ID: _____ Group Number: _____

Insurance address – usually PO box on back of card:

_____

Insurance phone number – usually on back of card: _____

Patient's relationship to subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Dental Insurance

SKIP section if you do not have a secondary dental insurance. If you have more than two policies, please keep in mind that we cannot bill to more than two dental insurances

Last name of subscriber: _____ First name of subscriber: _____

Subscriber's DOB: _____ Subscriber's employer name: _____

Insurance plan name: _____

Subscriber or Member ID: _____ Group Number: _____

Insurance address – usually PO box on back of card:

_____

Insurance phone number – usually on back of card: _____

Patient's relationship to subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance authorization

_____ **By initialing here**, I authorize the dentist to bill the above insurance(s) for services rendered. I authorize my insurance company to pay the dentist directly for services rendered. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges not paid by my insurance(s). I authorize use of this electronic signature on all insurance submissions.

Dental Information

What is your immediate concern? _____

Approximate date of most recent dental exam/xrays: _____

Previous dentist name, phone number: _____

Check all that apply:

☐ Dental anxiety
☐ Trouble getting numb
☐ Have or have had braces, clear aligners, or other orthodontic treatment
☐ Dry mouth
☐ Sensitivity to biting, pressure, cold, hot, sweets
☐ Food gets trapped between any teeth
☐ Interest in whitening
☐ Difficulty chewing
☐ Jaw pain, popping, clicking, or locking
☐ Clenching or grinding
☐ History of trauma/injury to jaw or face
☐ Gums bleed when brushing or flossing
☐ History of periodontal treatments or deep cleaning
☐ Unpleasant taste or odor in mouth
☐ Wear denture or partial
☐ Snoring or waking frequently at night
☐ Interest in botox or filler
☐ None of the above

If you would like to elaborate on any of the above, please do so here:

_____
_____
_____

Consent for Services

☐ I understand that it is very important that I provide the dentist with accurate information before, during and after treatment. I understand that it is equally important that I follow the dentist's advice and recommendations regarding medication, pre-treatment and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If I fail to follow the advice of the dentist, I may increase the chances of a poor outcome.

☐ I understand that I have the right to accept or reject dental treatment recommended by the dentist and that prior to consenting, I should fully consider the anticipated benefits and commonly known risks of the recommended procedure as well as alternative treatment options or no treatment. By consenting to treatment, I acknowledge my willingness to accept known risks and complications, no matter how slight the possibility of occurrence.

☐ By checking this box, I am granting permission for the dentist, dental hygienist(s), and dental assistant(s) to perform treatment within their scope of practice. I agree to basic dental treatments that may be required, including but not limited to examination, cleanings, x-rays, periodontal probing.

☐ I understand that dentistry is not an exact science, therefore reputable dentists cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have authorized. I understand that each dentist is an individual making treatment recommendations to the best of their ability with the available information and the patient's best interest in mind.

Office Policies

Thank you for choosing Pewaukee Smiles Dentistry. Our primary mission is to deliver comprehensive treatment that effectively addresses each patient's concerns and exceeds expectations. An important part of this mission is making the cost of optimal care manageable for our patients and easy to understand.

- As a condition of treatment of this office, financial arrangements must be made IN ADVANCE of treatment.
- Whether you have insurance benefits or none at all, PAYMENT in FULL is expected at the time services are performed. This includes deductibles and co-pays.
- Our office accepts cash, check, Apple Pay, and all major credit cards.
- In the event that you cancel an appointment within 24 hours or no show an appointment, you may be charged a $35 missed appointment fee. This fee must be paid before a new appointment can be made. We appreciate your understanding and respect for our providers' time.
- Patients with dental insurance
    - It is the patient's responsibility to be familiar with their plan benefits. We are happy to work with your insurance provider on your behalf to maximize your benefits and directly bill them for reimbursement for your treatment. In the event of denial by insurance, appeals will be submitted to dental insurance at the dentist's discretion.
- Patients without dental insurance
    - We offer an in-house discount plan which is only available for patients without dental insurance benefits.
    - For extensive treatment, we can design customized payment plans on a case by case basis. There will always be a down payment required at the start of treatment.

☐ **By checking this box**, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Office Policy.

Consent for Financial Policy

- In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, including deductibles and copays. In any case where payment is not made at the time of treatment, I agree to remit payment prompty when a statement is sent to me for any outstanding balance.
- I understand that if I have an unpaid balance to Pewaukee Smiles Dentistry and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. The office will attempt to the best of their ability to collect payment prior to sending an account to collections. I understand that in the event my account is sent to a collecetion agency, I will be responsible for reimbursement of any fees from the collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses incurred collecting my account, including reasonable attorney fees if so incurred during collection efforts.
- In order for Pewaukee Smiles Dentistry or their designated external collection agency to service my account, and where not prohibited by law, I agree that Pewaukee Smiles Dentistry and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device

as applicable. Furthermore, I consent to the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, email, and mail notification.

☐ **By checking this box**, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Consent for Financial Policy.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

By signing below, you certify that you have read through the entire document, agree with all of the above statements, acknowledge all disclosures, and consent to all policies. To your knowledge, all of the information in this form is accurate and complete.

If signing for someone else, please provide your name and relationship to the patient:

_____

Name (printed): _____

Signature: _____

Date: _____