PATIENT INFORMATION **DATE**_____

NAME_____ Please circle: MARRIED SINGLE MALE FEMALE
LAST FIRST M

SOCIAL SECURITY #_____ BIRTHDATE_____
MONTH DAY YEAR

ADDRESS_____
STREET APT# CITY STATE ZIP

TELEPHONE_____ E-MAIL_____
HOME WORK CELL

NAME & ADDRESS OF EMPLOYER_____

IF FULL TIME STUDENT, SCHOOL NAME_____

PERSON RESPONSIBLE FOR ACCOUNT & RELATIONSHIP TO YOU_____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE?_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

INSURANCE INFORMATION

PRIMARY (If no insurance complete for responsible party) _____
Last Name First Middle

Street City State Zip

Home Work Cell E-mail

Birthdate(MO/DAY/YEAR) Relationship to patient Social Security #

Employer Dental Ins CO & Phone # Group # Subscriber #

SECONDARY _____
Last Name First Middle

Street City State Zip

Home Work Cell E-mail

Birthdate(MO/DAY/YEAR) Relationship to patient Social Security #

Employer Dental Ins CO & Phone # Group # Subscriber #

EMERGENCY CONTACT

Name Address Home # Work# Cell#

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

SERVICE CHARGE

If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month and rebilling charges of at least $15.00 per billing cycle if your account is delinquent. In the case of default of payment, I promise to pay costs of collections, including reasonable attorney and administrative fees incurred to effect collection of this account or future outstanding accounts.

Patient/Responsible Party Signature_____ Date_____

State Driver's License #_____ Expiration Date_____

PATIENT NAME_____ DATE_____

Dental History

Please Circle

Yes No Do you have a specific dental problem? Describe_____
Yes No Do you have dental examinations on a routine basis? Last visit_____
Yes No Do your gums bleed?
Yes No Have you ever been told you have gum disease?
Yes No Do you smoke or chew?
Yes No Do you ever have clicking, popping, or discomfort in the jaw joint?
Yes No Do you brux or grind?
Yes No Have your past experiences in a dental office always been positive?
Yes No What would you change if anything about your smile?_____

Medical History

Are you under a physician's care now?_____Why?_____
Physician's name:_____Phone number:_____
Have you ever been hospitalized or had a major operation? Discuss_____
Have you ever had a serious injury to your head or neck?_____
Are you taking any medications?_____What?_____
Are you allergic to any medication or substances? Please check below.
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex rubber ☐ Other_____
Blood Pressure_____ Pulse_____

Do you now have, or have you ever had any of the following? Please circle.

Heart Disease	Recent Blood Transfusion	Liver Disease	Stroke
Heart Murmur	Swelling of Limbs	Hepatitis A (Infectious)	Convulsions
Irregular Heart Beat	Lung Disease	Hepatitis B or C	Epilepsy or Seizures
Angina/Chest Pain	Breathing Problems	Night Sweats	Fainting or Dizziness
Heart Attack/Failure	Shortness of Breath	Yellow Jaundice	Glaucoma
Congenital Heart Disorder	Frequent Cough	Kidney Problems	Tumors or Growths
Mitral Valve Prolapse	Hay Fever	Renal Dialysis	Nervousness
Artificial Heart Valve	Sinus Problems	Thyroid Disease	Psychiatric Care
Heart Pace Maker	Asthma	Parathyroid Disease	Alzheimer's Disease
Fen-phen side effects	Emphysema	Arthritis/Gout	Allergies (pollen/dust)
Heart Surgery	Tuberculosis	Rheumatism	Hives or Rash
High Blood Pressure	Cancer	Low Blood Pressure	Cortisone Medicine
Bloody Sputum	Chemotherapy	Artificial Joint	Unexplained Fever
Stomach/Intestinal disease	Venereal Disease	Bruise Easily	Ulcers
AIDS	Anemia	Recent Weight Loss	HIV Positive
Excessive Bleeding	Frequent Diarrhea	Drug Addiction	Sickle Cell Disease
Diabetes	Cold Sores	Hemophilia	Excessive Thirst
Fever Blisters	Leukemia	Hypoglycemia	Herpes

Women Only: Pregnant Trying to get pregnant Nursing Oral Contraceptives
(Please Circle)

Have you ever had any other medical conditions not checked above? What_____
Do you wish to talk to the dentist privately about any problem? _____
To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the Dentist and Team at the next appointment.

X_____ Date_____
Patient Signature or Parent/Guardian

Reviewed by Doctor_____Date_____

EXCEPTIONAL SMILES BY GREGORY M. SOLICH, DDS
10807 New Allegiance Dr. Suite 465
Colorado Springs, CO 80921
(719)548-9393

FINANCIAL POLICY AND PATIENT AGREEMENT

The following is the financial policy of Dr Solich, which we require that you read and sign prior to treatment at our office. (For the purpose of this Agreement, the terms "you" and "your" refer to the patient or the party responsible for the patient's care.)

Your portion of the payment is due at the time of service. Acceptable forms of payment are cash, personal check, and money order. We also accept Care Credit, Visa, MasterCard, American Express, and Discover card. Credit card transactions must be greater than $5.00 to be processed. Payments not made at the time of service are considered past due when you leave the facility. A re-billing fee will automatically be charged to your account if you fail to pay for services on the date of service.

Regarding Dental Benefit Plans: As a courtesy to patients, the practice will file claims with all standard benefit plans. You are responsible for making available to the practice complete and accurate information for the filing of claims, including all identification and benefit cards and documents. **If the benefit plan denies benefits for any reason, or if no payment is received from the plan within 45 days of the date of service, you will then be responsible for paying the full amount of the bill immediately.**

The practice's policy on accepting payments from benefit plans varies based on the type of plan, as follows:

Indemnity and Delta Premier Plans: Payments received from an Indemnity or Premier plan will be applied to your account, and you agree to pay the balance. If the practice has an agreement with your carrier, we will **estimate** the portion for which you are responsible at the time of service, and payment of the estimated amount, as well as any co-payment, is required at that time. Any necessary adjustments will be made once payment is received from the carrier, and you will be billed, or your account credited as applicable.

By signing this agreement:

1) You authorize the exchange of information relating to care and claims with your benefit plan(s), and authorize payments to be made directly to the practice for services provided under your dental benefit plan agreement, which are otherwise payable to you.

2) You agree special financing arrangements can only be made with an addendum to this document. You agree to pay a finance charge of 1.5% per annum and rebilling charges of at least $15.00 per billing cycle if your account is delinquent. You agree to pay costs of collections, including reasonable attorney and administrative fees if your account remains delinquent for 90 days or more.

3) You agree to pay a $20.00 service fee for any check returned not paid, and understand if, upon proper notice, such check is not paid in cash or certified funds in the time specified in the notice, you may be responsible for three times the face value of the check or $100.00 whichever is greater plus costs of collections, including reasonable attorney and/or administrative fees.

PATIENT/RESPONSIBLE PARTY AGREEMENT:

I have read and understand this Financial Policy, and agree to the terms stated herein.

Patient's/Responsible Party's Signature	Responsible Party's Printed Name
Date	Patient's Name and Date of Birth

EXCEPTIONAL SMILES BY GREGORY M. SOLICH, DDS
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
and
AVOIDING BREACHES OF CONFIDENTIALITY

****You may refuse to sign this acknowledgement****

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

_____
Patient or Guardian Printed Name

_____ _____
Signature Date

If you have a telephone answering machine or voice mail system, our staff may have the opportunity to leave messages for you. These messages may contain confidential information regarding your condition or the fact that you are our patient. People other than you may hear these messages. Please check all that apply.

_____Yes, Exceptional Smiles by Gregory M. Solich DDS staff may leave messages on my answering machine/voice mail.

_____Yes, Exceptional Smiles by Gregory M. Solich DDS staff may leave limited information on my answering machine Or voice mail. Limitations: Doctor's name, date and time of appointment, and return telephone number.

_____No, no messages are to be left. I will take responsibility for attending my appointment and/or following up on treatment questions. Exceptional Smiles by Gregory M. Solich DDS does not have to confirm my appointments. I fully understand it is my responsibility to pay any failed appointment charges if I miss my appointment.

There may be times when your spouse or an immediate family member will call to request information regarding your dental treatment, have questions regarding billing and insurance, or may be present in the office during your treatment and consultations.

_____Yes, Exceptional Smiles by Gregory M. Solich DDS staff may discuss my dental treatment with people whose names are listed below:
_____

_____

_____No, do not discuss my dental treatment with anyone other than me

_____
Patient's Printed Name

_____ _____
Patient's/Legal Guardian's Signature Date

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

_____

_____

How do you feel?

Name:_____ Date:_____ Age:_____

Please place a mark in the box next to anything you experience on a regular basis (at least 2 times per week).

1. ☐ Headaches
2. ☐ Jaw pain
3. ☐ Jaw noise
4. ☐ Difficulty opening
5. ☐ Ear congestion
6. ☐ Dizziness
7. ☐ Ringing in the ears
8. ☐ Difficulty swallowing
9. ☐ Loose teeth
10. ☐ Clenching
11. ☐ Facial pain
12. ☐ Tender, sensitive teeth
13. ☐ Difficulty chewing
14. ☐ Neck pain
15. ☐ Postural problems
16. ☐ Tingling of fingertips
17. ☐ Hot and cold tooth sensitivity
18. ☐ Nervousness
19. ☐ Insomnia

Thank you for taking the time to complete your paperwork. We will go over your information in full detail at your scheduled visit. We look forward to seeing you!

Smile Assessment

Yes	No	
❑	❑	Do you like to smile and show your teeth?
❑	❑	Are you happy with the way your teeth look?
❑	❑	Do you have unsightly crowns or fillings?
❑	❑	Are your teeth sensitive to hot or cold?
❑	❑	Are your teeth too long?
❑	❑	Are your teeth too short?
❑	❑	Do you brush your teeth too hard?
❑	❑	Are you missing teeth?
❑	❑	Are you interested in improving the appearance of your teeth?
❑	❑	Are you interested in tooth replacements?
❑	❑	Are you familiar with the benefits of implants?
❑	❑	Are your gums sensitive?
❑	❑	Do your teeth or gums hurt?
❑	❑	Are your gums receding?
❑	❑	Are you anxious or fearful of treatment?
❑	❑	Are you interested in esthetic (cosmetic) dentistry?

Please feel free to explain any answers.

_____

_____

_____

_____

_____

_____

_____

Name:_____

Exceptional Smiles by Gregory M. Solich DDS

AUTHORIZATION FOR CREDIT CARD PAYMENTS

As a convenience to our patients we offer credit card billing for payments or copayments due at the time of service. Placing your credit card number on file also allows us to process payments automatically to your card to balance your or your family's account for balances that may be left over after insurance payments. It reduces your bills at the end of the month and you won't have to send a check. After each transaction your account payment receipt will be given to you or mailed to your address on file.

All card information is kept securely in a program with limited access.

Please provide the option(s) most convenient for you to settle your account:

Visa Acct#_____ Exp Date_____ SVC_____

MasterCard Acct#_____ Exp Date_____ SVC_____

AmerExp Acct#_____ Exp Date_____ SVC_____

Discover Acct#_____ Exp Date_____ SVC_____

To better protect your privacy we will ask to see your credit card and photo ID at your first visit.

I hereby authorize Exceptional Smiles by Gregory M. Solich DDS to process payments to settle my account in full. This agreement is considered valid until written notification is received.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name