Welcome!

Thank you for selecting Facial 32 Dental Esthetics! We are so happy that you chose us to provide you with the best dental care. To help us meet your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help you.

Patient Information

First Name: ______________________ Last Name: ____________________________ Middle: _____________

DOB: ________________________________ Social Security #: ____________________________________

Gender: ☐ Male ☐ Female Married: ☐ Yes ☐ No ☐ Single ☐ Divorced ☐ Widowed

Home Phone: ____________________ Work Phone: ____________________ Cell #: ______________________

Email: ____

Address: ____

City: _______________________________________ State: _____________ Zip: _________________________

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text Message

Student Status if dependent over 19: ☐ Non Student ☐ Fulltime ☐ Parttime

How did you hear about us? ____

If someone referred you here, please enter their name so we can thank them. __________________________

If Minor, Name of Guardian/Parent ____

If student, Name of School/ College ____

Insurance Information

Name of Insured: ____

DOB: ______________________________________ Social Security #: ________________________________

Relationship to Patient: ____

Name of Employer: ____ Group #: ________________________

Insurance Company: ____

ID #: ____

Insurance Company Address: ____

City: ____ State: ______________ Zip: _________________

Patient Medical History

Physician: ____ Phone: ______________________

Date of Last Exam: ________________________

Are you under any medical treatment now? (Please circle) Yes No

If yes, please explain: ____

Have you had any hospitalizations /surgeries within the last 5 years? Yes No

If yes, please explain:

____

Are you taking any medications? Yes No

Please List Medications below.

Are you allergic to or have you had any reaction to the following? (Please check all that apply)

_____ Local Anesthetics
_____ Penicillin or any other Antibiotics
_____ Codeine
_____ Latex
_____ Sulfa Drugs
_____ Ibuprofen
_____ Aspirin
_____ Iodine
_____ Other

Do you have or have you had any of the following? (Please check all that apply)

_____ High Blood Pressure
_____ Heart Trouble
_____ Rheumatic Fever
_____ Fainting/ Seizures
_____ Low Blood Pressure
_____ Epilepsy/Convulsions
_____ Leukemia
_____ Diabetes
_____ Kidney Disease
_____ Joint Replacement
_____ Bleeding Problems
_____ Pregnancy
_____ AIDS or HIV Infection
_____ Thyroid Problem
_____ Cardiac Pacemaker
_____ Heart Murmur
_____ Angina
_____ Anemia
_____ Emphysema
_____ Cancer
_____ Arthritis
_____ Asthma
_____ Seizures
_____ Psychiatric treatment
_____ Chest Pains
_____ Stroke
_____ Hay Fever
_____ Tuberculosis
_____ Sinus Problems
_____ Glaucoma
_____ Liver Disease
_____ Respiratory Problems
_____ Mitral Valve Prolapse
_____ Hepatitis (Specify Type)
_____ Pacemaker
_____ Ulcers

Previous Dentist: ____ Last Exam: ______________________________

Do your gums bleed while brushing or flossing? Yes or No

Do you feel any pain to any of your teeth? Yes or No

Do you grind/clench your teeth? Yes or No

Have you had any orthodontic treatment? Yes or No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information medical/ dental information to other health practitioners if it is beneficial or crucial to my health.

____ ___________________________________

Signature of patient (or parent/ guardian if minor) Date

Please take a few moments to tell us about your smile.	Yes	No
Have you thought about improving the appearance of your smile?		
Would you like to straighten your teeth?		
Do you have spaces that you don't like?		
Are your teeth chipped?		
Would you like to whiten your teeth?		
Are your teeth wearing on the biting surfaces?		
What would you change about your teeth? (Circle all that apply) Shape Color Size Straighten		
Have you had any orthodontic treatment in the past?		
Do you have any skincare concerns? If so, please list them here. ____ ___________________________________		
Facial Questionnaire		
Do you have any skincare concerns that we can help you with? If so, please let us know. _______________________________ ____		
We will be able to help you address these concerns and speak with our Esthetician if needed		

Administrative Requirements:

All new patients are required to complete in its entirety: ALL patient information forms, patient history, questionnaires, and consent forms such as HIPAA, appointment policy, financial policy, covid policy and patient responsibility forms. At all appointments, you will be asked to update medical history and to give our office any updated insurance information. This is your responsibility.

I have read and understand the Administrative Requirements of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I, ____ (print name), have received a copy of Facial 32 Dental Esthetic's Administrative Requirements.

Signature: ____ Date: _______________________

Appointment Cancellation Policy

To provide you with the best service possible, we need your cooperation in keeping appointments. Your appointment time has been reserved exclusively for you, and any changes may affect other patients. When it is necessary to change an appointment, we require a minimum **24-hour notice**, making it possible for another patient to use that scheduled time. If we are not given 24-hour notice, an **Appointment Cancellation** fee will be charged.

Our Policy is as follows:

The first time you break an appointment without proper notification, we will waive the charge as a courtesy. For any further missed appointments or cancellations made less than a 24-hour notice, there will be a charge of $50.00 billed to your account. This fee must be paid prior to your next appointment; this fee cannot be billed to your insurance company and will be your direct responsibility. After the third missed appointment, we will need a prepayment for any future appointments. We understand unforeseen circumstances arise, and we will take your situation into consideration. We realize accidents happen, family member gets sick, and emergencies occur. We will do our best to accommodate these rare occasions with grace, but please remember we track these occurrences as to prevent abuse of the policy. Arriving early for an appointment does not necessarily mean you will be seen early. If you arrive late, you will need to wait until you can be fit into the schedule. If you miss your appointment, you will be subject to the service fee for all future missed appointments.

Thank you for your cooperation and understanding in this matter. The policy exists to maintain our service expectations and to respect all our patients' and team's time. We appreciate your help in continuing to provide you with the best possible dental care. If you have any questions or concerns regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

Appointments for Minors

All patients under the age of 18 must be accompanied by a parent or legal guardian throughout the entire exam.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I, ____ (print name), have received a copy of Facial 32 Dental Esthetic's Appointment Cancellation Policy.

Signature: ____ Date: _______________________

Financial Policy

At Facial 32 Dental Esthetics, we believe that you deserve the best dental care available. As a cutting-edge dental practice, we provide the most current dental technology to our patients. In order for our office to consistently provide these services, it is necessary for you to understand your financial responsibilities.

Many patients count on dental insurance to help with the cost of their treatment, but unlike medical insurance, dental insurance DOES NOT typically cover 100% of any treatment and is never a guarantee of payment. We encourage all our patients to become familiar with your plan policy before scheduled appointments with us. We cannot be accountable for every stipulation written in the many numbers of different insurance plans. To expedite your care, please be prepared to share any update in your insurance policy at the beginning of your visit.

When you schedule dental treatment in our office, we will give you an estimated treatment plan explaining the full charge. Facial 32 Dental Esthetics is a FEE FOR SERVICE office, which means that we do not accept your insurance, but we will be happy to submit a claim to your insurance company and it will be considered out-of-network. The insurance company will, therefore. Pay the guarantor (The policy holder).

Patient Responsibility

At the time of service, you will be financially responsible for paying for the services provided. Regardless of insurance, payment remains your responsibility. We will then submit a claim to your insurance. The insurance company will then pay you. Again, dental insurance is never a guarantee of payment. The person bringing a child or minor patient (regardless of relation) must be prepared to satisfy any financial responsibilities for that child's appointment at the time of service. If you have dental insurance or do not have dental insurance coverage, you will be expected to pay in full at the time services are rendered unless a previous payment agreement has been discussed and signed. All balance that reach 90 days past due will be sent to an outside collection agency. You will be responsible for all collection fees, interest, and/or legal fees incurred and waive all confidentially due to public records. A 25%-30% collection fee will be added to all accounts sent to an outside collection agency. All balances must be paid in full prior to any future appointments.
By understanding this financial policy, you will allow us to focus on your optimal dental health.

Your signature below confirms that you have read out policy and will abide by it.
Patient: ____
Parent (or Guardian) Signature: ____ Date: _____________________

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. I understand that information supplied by me, or my representatives, can and will only be used to:

* Conduct, plan and direct my dental treatment and for follow-up among multiple health care providers that may be involved in my treatment either directly or in-directly.
* Obtain payment or information from my dental insurance company. This includes verifying benefits and claim status.
* Call any number provided by patient to confirm appointments. This will also include mailing, emailing, or texting reminders for my next appointment.
* Conduct normal business operations.

I have received, read, and understand your Notice of Privacy Practices containing a more detailed explanation of the uses and disclosures of my protected health information. I understand that Facial 32 Dental Esthetics, L.L.C. has the right to change it Notice of Privacy Practices from time to time, and that I am entitled to receive a copy at any time by their office at 717-316-0733.

I also understand that I may request in writing that Facial 32 Dental Esthetics, L.L.C. restrict how my protected health information is used or disclosed to carry out my dental treatment, obtain payment or health care operating. I understand that Facial 32 Dental Esthetics, L.L.C. is not required to agree to my request. However, if they do, they are required by law to abide by my restrictions.

By signing below, I acknowledge receipt of the Notice of Privacy Practices and give my consent to use my protected health information supplied to this office in the way listed above. I understand that any other disclosures besides what is listed above require signed authorization.

Do you authorize us to leave detailed messages at your home and/or on your voicemail? Yes No
With whom do you authorize us to speak concerning treatment? ____________________________________
Their relationship to you, the patient ____
I have reviewed, understood and agreed to the content of the notice of privacy.
Patient Name: ____
Signature of Patient or Guardian: ____Date: __________________________________

There is no expiration of this form unless otherwise noted by the patient.
Office Use Only:I attempted to obtain the patient's signature in acknowledgement to the Notice of Privacy Practices notice but was unable to do so as stated below.
Date: _______________________________________ Initials: ________
Reason: ____