FACIAL 32
DENTAL ESTHETICS

FAMILY smiles DENTISTRY

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	____ Latex	____ Aspirin
____ Penicillin or any other Antibiotics	____ Sulfa Drugs	____ Iodine
____ Codeine	____ Ibuprofen	____ Other

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

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

FACIAL 32
DENTAL ESTHETICS

FAMILY smiles DENTISTRY

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: _____

Financial & Appointment 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 and we need your cooperation in keeping appointments. Your appointment time has been reserved exclusively for you, and any changes may affect other patients. **When the first appointment is scheduled, we require a $50 deposit to hold your appointmetn slot. We will take this as soon as the appointment is made. 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 in the amount of $50.00. If there is a NO-SHOW for the appointment, a charge of $100 will be charged to your account to the card on file.**

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.

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 a 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).

Appointments for Minors

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

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 directly. 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.

I have read and understand the Appointment Cancellation Policy & Financial 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 Financial & Appointment Policy.
Signature: _____ Date: _____

Social Media & Website Consent Form

Thank you for choosing Facial 32 Dental Esthetics. We respect your privacy and comply with HIPAA. By signing below, you authorize us to use images, videos, and testimonials related to your treatment for marketing, educational, and promotional purposes on platforms such as social media, websites, and print materials.
By signing, you give Facial 32 Dental Esthetics permission to use your images/videos for:
· Social media platforms (e.g., Facebook, Instagram, TikTok)
· Marketing, promotional, and educational materials (e.g., websites, ads, brochures)
You authorize Facial 32 Dental Esthetics to use your first name and the initial of your last name in association with any images, videos, or testimonials used, while respecting your privacy. We will not disclose your full name, address, contact information, or other protected health information (PHI) unless specifically authorized by you in writing. We further assure you that no images or videos will be sold or distributed to third parties without your express consent.
We are committed to protecting your privacy as required by HIPAA. By signing this consent form, you acknowledge that the images, videos, or testimonials shared by Facial 32 Dental Esthetics may be considered PHI under HIPAA guidelines. You understand that while we will take reasonable steps to ensure your privacy is protected, the media content you authorize may be shared or accessed through public channels, which may carry a limited risk of unintended disclosure of PHI.
By signing, you release Facial 32 Dental Esthetics from any claims related to the use of your media, including defamation, invasion of
* Please select one of the following:
Full Image Use (including face):
YES ☐ NO ☐ I consent to the use of my/my child's full-face photos/videos.
Smile/Teeth-Only Use:
YES ☐ NO ☐ I consent to the use of smile/teeth images/videos only.

You may revoke your consent in writing at any time. Revocation applies only to future uses, not already published material. privacy, or publicity rights. Your participation is voluntary, and declining consent will not affect your dental care.

First Name: _____ Last Name Initial: _____
Patient Signature: _____ Date: _____

FACIAL 32
DENTAL ESTHETICS

FAMILY Smiles DENTISTRY

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: _____