Welcome to Elite Smiles!

We are so pleased that you have chosen our office for your dental needs! We are excited to begin our professional relationship with you. We intend to foster a caring, honest Doctor-Patient rapport. We understand the need for straightforward communication, and with that in mind, we kindly ask you review our office policies.

Cancellation/Late Policy

Dr. Shreeve and the Team know your time is valuable. We do our very best to be on schedule each day, so we may provide every patient the highest standard of care. While we understand life happens, we must be conscientious of all our patients' schedules. We reserve convenient times specifically for you upon scheduling with the intent of fitting into your busy schedule. With that in mind, we request 24-hour notice for any cancellations. We reserve the right to charge a $50 cancellation fee for missed appointments.

Free Whitening for Life

We offer free whitening to all our valued patients of good record. We consider it a great reward to our patients who maintain outstanding oral hygiene. We make custom-fitted take-home trays and send the whitening gel home with you to maintain your beautiful smile! The guidelines for this program are as follows:

· Patient must be at least 18 years old · Have completed an initial Hygiene Cleaning, X-Rays, and Exam with Dr. Shreeve and return to our office for your recommended continued care visit (your next 3 or 6-month cleaning appointment)
· Have completed all necessary dental treatment
· Arrive on time for your scheduled appointments and allow requested 48-hour notice for cancellations
· Have no outstanding balances on your family account

Upon meeting all these guidelines at your second cleaning appointment, we will create your custom trays and explain in detail the program and instructions. Impressions are taken the same day, and at each scheduled hygiene appointment you will be given a free tube of whitening gel. Ask the front desk for more information!

Deposit Policy

Some dental procedures will require a deposit of 10% the total fee due at scheduling. These procedures require considerable time and preparation from Dr. Shreeve and the staff at Elite Smiles. The deposit is held on your account and is intended to safeguard your reservation. This deposit is meant to be applied toward treatment on the date of service. To avoid forfeiture, we will require notice 48 hours in advance should any scheduling conflict arise. Without proper notice, we reserve the right to apply all or part of your deposit to accommodate for the cancellation. In the event unavoidable and unforeseen circumstances arise, please contact the Office Manager directly at 480-924-5577 to make alternate arrangements.

If you have any questions or concerns regarding our office policies, please ask! If we can make your experience more comfortable in any way, please let us know. We value your business and look forward to helping you achieve your best smile!

- Dr. Blake Shreeve and the Team

Elite Smiles
DENTAL HEALTH & WELLNESS

Name: _____ **Preferred Name**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Email: _____ **Phone**: (____)_____**Is this a Cell**: Yes/No

Social Security Number: _____ **Date of birth**: _____

Check Appropriate Box: ☐ **Child/Minor** ☐ **Married** ☐ **Single** ☐ **Student**

How did you hear about our office? _____

Person to contact in case of an emergency: _____ **Phone**: (___)_____

Responsible Party: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other**

Address if different from above: _____ **City**: _____ **State**: _____

Zip:_____ **Phone if different from above**: (___)_____

Insurance Information

Name of Insurance: _____

Name of Insured: _____ **Date of Birth**: _____

Member ID: _____ **Group Number**: _____

Employer: _____ **Insurance Phone Number**: _____

Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Dependent**

Secondary Insurance

Name of Insurance: _____

Name of Insured: _____ **Date of Birth**: _____

Member ID: _____ **Group Number**: _____

Employer: _____ **Insurance Phone Number**: _____

Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Dependent**

Notice of Privacy Practices Acknowledgement

By signing this form, you will consent to our use and disclosure of your protected health information (PHI) for the following purposes:

- To conduct and plan treatment, including multiple healthcare providers who may be involved in treatment directly or indirectly.
- To obtain payment for services provided to you through third-party payers.
- To conduct normal healthcare operations such as quality assessments, etc.

I have received/been offered a copy of the above-named office's Notice of Privacy Practices (NOPP) containing a detailed description of the uses and disclosures of my PHI.

We reserve the right to change our privacy practices as described in our NOPP, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

I understand that I have the right to revoke this consent at any time by giving written notice of revocation submitted to the office. 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 continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and this office's NOPP. I understand that, by signing this consent, I am giving my consent your use and disclosure of my PHI to carry out treatment, payment activities, and health care operations.

Print Name

Patient or Guardian Signature Date

Office Use Only

_____ Individual Refused to Sign

Signature of Office Manager Date

Elite Smiles
DENTAL HEALTH & WELLNESS

Dental History/Concerns

Name: _____ **Date of last exam**_____ **Today's Date**: _____

Please answer to the following questions:

Y N Bad Breath	**Y N** Loose/Broken Fillings	**Y N** Clicking/Popping Jaw
Y N Bleeding Gums	**Y N** Grinding/Clenching	**Y N** Sensitivity(hot,cold,sweets)

Was there anything you didn't like about your last dental office?

_____

What did you like about your last dental office? _____

Please select from the list below of Dental Services that we may help you with:

Family Dentistry	**Sedation**	**Whitening**
Veneers/Crowns	**Bite Correction**	**Dental Health**
Sleep Apnea	**Implants**	**Fillings**

When deciding about your health needs/wants, what words below are important to you when choosing your dental care treatment?

Finances	**What insurance covers**	**Time**	**Relationship with your dental team**
Health	**Necessary**	**Beauty/Aesthetic**	**Comfort**
Details	**Quality**	**Technology**	**Services Offered**

Medical History

Y N AIDS/HIV	**Y N** Blood disease	**Y N** Artificial joints	**Y N** Liver problems
Y N Anxiety/Depression	**Y N** Cancer	**Y N** Headaches	**Y N** Tuberculosis
Y N ADD/ADHD	**Y N** Circulatory problems	**Y N** Heart murmur	**Y N** Ulcer/colitis
Y N Arthritis	**Y N** Chemotherapy	**Y N** Heart problems	**Y N** Diabetes
Y N Artificial heart valve	**Y N** Mitral valve prolapse	**Y N** Hemophilia	**Y N** Dry mouth
Y N Asthma	**Y N** Nervous problems	**Y N** Herpes	**Y N** Psychiatric care
Y N High blood pressure	**Y N** Epilepsy	**Y N** Hepatitis	**Y N** Radiation treatment
Y N Back problems	**Y N** Allergies	**Y N** Kidney problems	**Y N** Respiratory issues
Y N Stroke	**Y N** STD	**Y N** Tobacco habit	**Y N** Pace maker
Y N Recreational drugs	**Y N** Pregnant (women)	**Y N** Thyroid issues	**Y N** Shingles

Please list all allergies: _____

Please list all medication: _____

Office Policies

Please review and Initial the following information to enhance communication and promote understanding regarding this office's financial policies. Please provide your signature, indicating you fully understand these policies. This form must be signed in order to move forward with your scheduled appointment. If you have any questions or concerns, please ask to speak to the office manager. Thank you for allowing us to serve you and your family!

MISSED APPOINTMENTS/ NO SHOWS: We request at least **24-hour notice** to cancel or reschedule an appointment. If required notice is not received, a charge of **$50** will be applied to an individual's account and must be paid prior to next appointment. If you have an emergency, please ask to speak with the office manager for arrangements. **Initials:**_____

INSURANCE: We are happy to bill primary and secondary insurances as a courtesy to our patients. It must be understood that each patient is responsible for the cost of services rendered**. We will do our best to accurately estimate insurance coverage and patient amount due; however, in the event your insurance company does not pay the amount anticipated, the patient will be responsible for the difference.** Payment is expected within 30 days of receipt statements. **Initials:**_____

PATIENT PAYMENT: The patient portion for services rendered is expected at the time of service unless previous arrangements have been made with the office manager. We accept cash, checks, and all major credit cards. **Initials:**_____

FINANCING: We have financing options available through Care Credit. If you have an interest in this option, please consult the office manager prior to the date of the scheduled treatment. **Initials:**_____

REFUNDS: If a patient decides to discontinue treatment after it has commenced, a full refund is not available. Individual circumstances will be discussed with the office manager and/or Dr. Shreeve. If a patient out of pocket was more than an insurance estimation of benefits (EOB) states, a refund can be granted once all claims have been paid for. **Initials:**_____

COLLECTIONS: After repeated attempts to collect a balance due, we may need to turn an account over to a collection's agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection costs, attorney fees, and any other costs incurred while attempting to collect an outstanding balance. **Initials**:_____

Signature:_____ **Date**:_____