WELCOME! IF YOU HAVE ANY QUESTIONS REGARDING THESE FORMS, PLEASE ASK A TEAM MEMBER AT THE FRONT DESK. THANK YOU FOR CHOOSING GOTTA SMILE DENTISTRY!

PATIENT INFORMATION

Today's Date: _____/_____/_____ Married Single Child Other

Name: _____ Nickname: _____
FIRST M LAST

Birth Date: _____/_____/_____ Male / Female Social Security #: _____-_____-_____

Home Address: _____ apt. #_____

City: _____ State: _____ Zip Code: _____

NAME OF EMPLOYER: _____ EMPLOYER ADDRESS: _____

Medical Insurance Company:_____ Dental Insurance Company:_____

HOW MAY WE CONTACT YOU?

CELL: ( ) _____-_____ Email: _____

HOME: ( ) _____-_____ WORK: ( ) _____-_____ ext: ____

Emergency contact:( ) _____-_____ Relationship: _____

IF PATIENT IS NOT RESPONSIBLE FOR THE ACCOUNT, PLEASE FILL OUT GUARANTOR INFORMATION BELOW:

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ RELATIONSHIP: _____

SOCIAL SECURITY: _____-_____-_____ BIRTH DATE: _____/_____/_____

PHONE NUMBER: ( ) _____-_____ EMPLOYER: _____

WHO MAY WE THANK FOR REFERRING YOU? NAME: _____ RELATIONSHIP: _____

OR DID YOU FIND US ON YOUR OWN? PLEASE LET US KNOW HOW YOU FOUND US! (PLEASE BE SPECIFIC)

GOOGLE_____ 1 (800) DENTIST_____ INSURANCE CO. _____ GOTTASMILE.NET_____ YAHOO_____ YELP_____ OTHER_____

WE WOULD LOVE TO KNOW MORE ABOUT YOU AND YOUR SMILE!

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

IF YOU COULD CHANGE ONE THING ABOUT YOUR SMILE, WHAT WOULD IT BE? _____

WHAT ABOUT YOUR SMILE IS MOST IMPORTANT TO YOU? _____

ARE YOU INTERESTED IN WHITENING OR ANY COSMETIC ENHANCEMENTS? _____ ASK US ABOUT LUMINEERS!

WOULD YOU LIKE A COMPLIMENTARY PHOTO OF WHAT YOU WOULD LOOK LIKE WITH A WHITER, BRIGHTER SMILE?_____

Have you ever had? (Please circle all that apply)

Ortho treatment (braces) Oral Surgery? Periodontal Treatment? Mouthguard? Serious mouth injury? Upsetting dental visit?

Please turn page over for Medical and Dental History

MEDICAL HISTORY

THIS INFORMATION IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE.

TODAY'S DATE: _____/_____/_____

NAME: _____ BIRTH DATE: _____/_____/_____

PRIMARY PHYSICIAN'S NAME: _____ PHONE: ( ) _____-_____

PHYSICIAN'S ADDRESS: _____

ARE YOU CURRENTLY TAKING ANY MEDICATION OR DRUGS? (INCLUDING OVER THE COUNTER) YES / NO

If YES, please list the medications here:

Have you been under the care of a medical Doctor in the past 2 years? YES / NO

Do you smoke or use tobacco in any form? YES / NO

Have you every taken FOSAMAX, ACTONEL, BONIVIA or any other (bones) biphosphonate? YES / NO

Have you ever taken any dietary supplements such as fen-phen/phentermine/redux? YES / NO

Are you taking any BLOOD THINNERS or medication used as a blood thinner? (aspirin etc.) YES / NO

Are you required to take a pre-med (antibiotics) before medical/dental procedures? YES / NO

Food Allergy: _____ Special/Restricted Diet: _____

ARE YOU ALLERGIC TO OR HAVE EVER REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS? (Please CIRCLE)

ASPIRIN LOCAL ANESTHETIC ERYTHROMYCIN PENICILLIN CODEINE LATEX OTHER:_____

Please circle YES or NO the following which you have had or presently have:

AIDS	YES / NO	COUGH UP BLOOD	YES / NO	HIV	YES / NO	TONSILLITIS	YES / NO
ANAPHYLAXIS	YES / NO	DIABETES TYPE: ONE / TWO		JAW PAIN	YES / NO	TUBERCULOSIS	YES / NO
ANEMIA	YES / NO	EMPHYSEMA	YES / NO	KIDNEY DISEASE	YES / NO	TUMORS	YES / NO
ARTHRITIS	YES / NO	EPILEPSY/SEIZURES	YES / NO	LIVER DISEASE	YES / NO	ULCER COLITIS	YES / NO
ARTIFICIAL HEART VALVES	YES / NO	FAINTING	YES / NO	MITRAL VALVE PROLAPSE	YES / NO		
ARTIFICIAL JOINTS	YES / NO	GESTATIONAL DIABETES	YES / NO	NERVOUS PROBLEMS	YES / NO	IF YOU HAVE A DISEASE/CONDITION NOT LISTED, PLEASE LIST:	
ASTHMA	YES / NO	GLAUCOMA	YES / NO	PSYCHIATRIC CARE	YES / NO		
ATOPIC	YES / NO	HAY FEVER	YES / NO	RAPID WEIGHT: LOSS / GAIN			
BACK PROBLEMS	YES / NO	HEART ATTACK	YES / NO	RADIATION TREATMENT	YES / NO		
BLOOD TRANSFUSION	YES / NO	HEART DISEASE	YES / NO	RESPIRATORY DISEASE	YES / NO		
BLOOD DISEASE	YES / NO	HEART MURMUR	YES / NO	RHEUMATIC FEVER	YES / NO		
BLOOD PRESSURE: HIGH / LOW		HEART PROBLEMS	YES / NO	SHINGLES	YES / NO		
CANCER:_____	YES / NO	HEART PACEMAKER	YES / NO	SHORTNESS OF BREATH	YES / NO		
CHEMICAL DEPENDENCY	YES / NO	HEART SURGERY	YES / NO	SKIN RASH	YES / NO		
CHEMOTHERAPY	YES / NO	HEMOPHILIA	YES / NO	SLEEP APNEA	YES / NO		
CHEST PAIN	YES / NO	HERPES	YES / NO	SPINA BIFIDA	YES / NO	FOR WOMEN:	
CIRCULATORY PROBLEMS	YES / NO	HEPATITIS A B C		STROKE	YES / NO	ARE YOU PREGNANT?	YES/NO
CONTACT LENSES	YES / NO	HIGH BLOOD PRESSURE	YES / NO	SURGICAL IMPLANT:_____		If so, how far along? _____	
CORTISONE TREATMENTS	YES / NO	HIGH CHOLESTEROL	YES / NO	SWELLING OF: FEET / ANKLES		NURSING? YES/NO	
COUGH (PERSISTENT)	YES / NO	HIVES	YES / NO	THYROID DISEASE	YES / NO	BIRTH CONTROL?	YES/NO
						VENEREAL DISEASE	YES/NO

DENTAL HISTORY

DATE OF LAST DENTAL EXAM? _____

PREVIOUS DENTIST'S NAME: _____

REASON YOU LEFT YOUR LAST DENTIST? _____

DATE OF LAST CLEANING? _____

WHAT TYPE OF CLEANING WAS IT (REGULAR, DEEP)? _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____

HOW OFTEN DO YOU FLOSS? _____

BESIDES (BRUSH, PASTE, FLOSS) WHAT AIDS DO YOU USE? _____

HAVE YOU NOTICED ANY BAD ODORS OR TASTES? YES NO

DO YOUR GUMS BLEED? YES NO

DO YOUR GUMS BECOME SORE OR TENDER? YES NO

DO YOUR GUMS GET SWOLLEN? YES NO

DO YOU GET COLD SORES, BLISTERS OR ANY OTHER LESIONS? YES NO

HAVE YOUR PARENTS EXPERIENCED GUM DISEASE OR TOOTH LOSS? YES NO

DOES FOOD TEND TO GET CAUGHT IN BETWEEN YOUR TEETH? YES NO

ARE YOUR TEETH SENSITIVE TO: (PLEASE CIRCLE ALL THAT APPLY)

HOT? COLD? SWEETS? BITING/CHEWING?

I understand the above medical information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my medical doctor who may release such information to you. I will notify the dentist in any changes to my health or medication.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____/_____/_____

DOCTOR'S SIGNATURE _____ DATE _____/_____/_____

CONSENTS

CONSENT FOR TREATMENT

I hereby authorize Gotta Smile Dentistry and staff to take X-Rays, study models, photographs and other diagnostic aids appropriateby doctor and staff to make a thorough diagnosis. Upon such diagnosis, I authorize Doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedativesand other medication necessary. I fully understand that using anestheticagents embodies certain risks. _____(initial)

CONSENT FOR ANNUAL ORAL CANCER SCREENING

The doctor or the hygienist will give both a visual exam and an Oral ID Exam, which helps identify suspicious areas at their earliest stages. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. I consent to annual routine oral cancer screening exams._____(initial)

CONSENT FOR PHI (Personal Health Information)

I give consent to the doctors and staff's use and disclosure of any oral, written or electronic health records that are individuallyidentifiable as mine for the purpose of carrying out my treatment, payment and health care operations.
I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my PHI is available. _____(initial)

You may ask a member of the front staff for a copy of our Notice of Privacy Practices.

FINANCIAL POLICY

It is our continued commitment to provide the highest quality dental care available to all of our patients. To make dental services comfortably affordable, we are pleased to offer you these options for payment.

PERSONAL CREDIT CARDS

VISA MasterCard DISCOVER AMERICAN EXPRESS

PREPAYMENT AND DISCOUNTS

WE ARE HAPPY TO OFFER A 5% DISCOUNT FOR SERVICES OVER $300 WHEN PREPAID IN FULL UPON SCHEDULING YOUR APPOINTMENT.

WE ALSO OFFER A 5% SENIOR DISCOUNT TO OUR PATIENTS 65+ and to our Active or Veteran Military Members.

WE ARE PLEASED TO OFFER FINANCING OPTIONS WHICH ARE ADMINISTERED FOR US BY:

CareCredit℠
Making care possible...today.

PLEASE ASK OUR ADMINISTRATIVE STAFF FOR DETAILS. (CARE CREDIT APPLICATION ON BACK)

Returned check fee: $25_____(initial)

MISSED APPOINTMENTS

Appointment times are reserved especially for you. If for any reason you should need to change your appointment, there will be no charge, provided you give us 48-hour notice. If notice is less than 4 hours, you will receive a $50 charge. Please help us serve you better by keeping your scheduled appointment. A missed WEEKEND APPOINTMENT will be a charge of $100. After the first missed WEEKEND Appointment, your WEEKEND scheduling will be revoked. _____(initial)

DISCONTINUING TREATMENT AFTER PROCEDURE START

If you for any reason decide to not finish your treatment that has already been started, we will charge you 20% of the original price of the unfinished treatment. If impressions have already been taken for that procedure, there will not be a refund (Lab fee, Doctor's time, etc.)_____(initial)

COPY OF RADIOGRAPHS

A $35 fee will be charged for any duplication of X-Rays or patient chart information request._____(initial)

I agree that I am fully responsible for the total payment of all procedures performed in this office-this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due to be paid in full within sixty (60) days of the date of service, regardless of whether or not my insurance benefits have been received. One and a half-percent (1.5%) per month interest (1% per year) will be charged on accounts 60 days from treatment date._____(initial)

PATIENT/GUARDIAN SIGNATURE_____ DATE _____/_____/_____

OPTIONAL

CareCredit®

APPLICATION AND CREDIT CARD ACCOUNT AGREEMENT

Credit is extended by Synchrony Bank.

Submit the application:
For providers, (800) 859-9975 or CARECREDIT.COM/PRO
For patients/clients, (800) 365-8295 or CARECREDIT.COM

ESTIMATED FEE $	**Office Merchant #**	Signature of Provider (New York Providers Only) X Date			Pre-Approval Offer ☐ Accepted ☐ Refused Date	
ID verified (initial):	Applicant 1st ID Type ☐ Driver's License ☐ State Issued ☐ Federal Government	Issuance State	Exp. Date	Applicant 2nd ID Type / Issuer		Exp. Date
	Joint Applicant ID Type ☐ Driver's License ☐ State Issued ☐ Federal Government	Issuance State	Exp. Date	Joint Applicant 2nd ID Type / Issuer		Exp. Date
Provided by Synchrony Bank:	Account #	Authorization #	or Key #	Approved Credit Limit		

****MARRIED WI residents only:** If you are applying for an individual account and your spouse also is a WI resident, combine your and your spouse's financial information.

1. APPLICANT INFORMATION: Please tell us about yourself. Please note that you must reside in the United States and be 18 years or older to apply.

Name (First-Middle-Last) Please Print		Date of Birth / /	Social Security Number/ITIN - -	Home Phone Number* ( )
Mailing Address	Apt.# City State ZIP			Cell/Other Phone Number* ( )
If the above address is a P.O. Box, you **must** provide a street address for yourself or a contact person. Contact Person Name	Street Address (Street Name and Number)		☐ Your Address? City	☐ Contact Person? State ZIP
Housing Information ☐ OWN ☐ RENT ☐ OTHER	Alimony, child support or separate maintenance income need not be included unless relied upon for credit. You may include the monthly amount that you have available to spend from your assets.**	Monthly Net Income From All Sources $		Business/Work Phone Number* ( )
Email Address (optional)*	*You authorize Synchrony Bank ("SYNCB") to contact you at each phone number you have provided. By providing a cell phone number and/or email address, you agree to receive account updates and information, including text messages, from CareCredit LLC, providers that accept the CareCredit credit card and Synchrony Bank. Standard text messaging rates may apply.			

2. JOINT INFORMATION: An additional card will be issued to the person indicated below. The applicant (and joint applicant, if any) will be liable for all transactions made on the account including those made by any authorized user. JOINT APPLICANT: You agree that we may send notices to you and/or applicant at the applicant's address, regardless of whether you live at that address.

Name (First-Middle-Last) Please Print		Date of Birth / /	Social Security Number/ITIN - -	Home Phone Number* ( )
Mailing Address	Apt.# City State ZIP			Cell/Other Phone Number* ( )
If the above address is a P.O. Box, you **must** provide a street address for yourself or a contact person. Contact Person Name	Street Address (Street Name and Number)		☐ Your Address? City	☐ Contact Person? State ZIP
Housing Information ☐ OWN ☐ RENT ☐ OTHER	**Alimony, child support or separate maintenance income need not be included unless relied upon for credit. You may include the monthly amount that you have available to spend from your assets.	Monthly Net Income From All Sources** $		Business/Work Phone Number* ( )
Email Address (optional)*	*You authorize Synchrony Bank ("SYNCB") to contact you at each phone number you have provided. By providing a cell phone number and/or email address, you agree to receive account updates and information, including text messages, from CareCredit LLC, providers that accept the CareCredit credit card and Synchrony Bank. Standard text messaging rates may apply.			

3. APPLICANT and JOINT APPLICANT: We need your signature(s) below.

By applying for this account or accepting a prescreen offer, I am asking Synchrony Bank ("SYNCB") to issue me a CareCredit Credit Card (the "Card"), and I agree that:

- I am providing the information in this application to SYNCB, CareCredit LLC, and providers that accept the Card and program sponsors (and their respective affiliates). I also provide my consent for SYNCB to provide information about me (even if my application is declined or my account is not opened) to CareCredit LLC, providers that accept the Card and program sponsors (and their respective affiliates) so that they can create and update their records, and provide me with service and special offers.
- SYNCB may obtain information, including employment and income information, from others about me (including requesting reports from consumer reporting agencies and other sources) to evaluate my application or determine whether to open my account, and to review, maintain, or collect my account.
- I consent to SYNCB, and any other owner or servicer of my account, contacting me about my account, including through text messages, automatic telephone dialing systems and/or artificial or prerecorded voice calls for informational, servicing or collection related communications, as provided in the Address/Phone Change and Consent To Communications provisions of the CareCredit Credit Card agreement ("Agreement"). I also agree to update my contact information.
- I have received, read and agree to the credit terms and other disclosures in this application, and I understand that if my application is approved or an account is opened, the Agreement will govern my account. Among other things, the Agreement: **(1) includes a resolving a dispute with arbitration provision that limits my rights unless I reject the provision by following the provision's instructions;** and (2) makes each applicant responsible for paying the entire amount of the credit extended.
- **Applicants applying for credit arranged by a provider in California only:** I have received and signed a notice that I received from my provider entitled "Credit or Loan for Health Care Services".

PLEASE SEE NEXT PAGE FOR RATES, FEES AND OTHER COST INFORMATION.

Federal law requires SYNCB to obtain, verify and record information that identifies you when you open an account. SYNCB will use your name, address, date of birth, and other information for this purpose.

If I have been pre-approved, I request that you open the type of account for which I was pre-approved. I have read the Prescreen Disclosures, credit terms and other disclosures on the next pages and have been provided my credit limit applicable to the account. SYNCB reserves the right to refuse to open an account in my name if SYNCB determines that I no longer meet SYNCB's credit criteria or if I do not have sufficient income.

If you apply with a Joint Applicant, each of you will be jointly and individually responsible for obligations under the Agreement and by signing below, you each agree that you intend to apply for joint credit.

Signature of Applicant		Signature of Joint Applicant (If Applicable)	
X (Please Do Not Print)	Date	X (Please Do Not Print)	Date

182-077-00
REV 062017

PLEASE READ THE SYNCHRONY BANK CREDIT CARD ACCOUNT AGREEMENT BEFORE SIGNING THIS APPLICATION.

Gotta Smile Dentistry
1035 W. Robinhood Drive
Suite 200
Stockton, CA 95207

Medical Information Release

Your Signature is necessary for us to:

- PROCESS ALL INSURANCE CLAIMS
- ENSURE PAYMENT FOR SERVICES RENDERED
- RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
- RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES WHEN NECESSARY FOR YOUR TREATMENT.
- PROVIDE EXCELLENT DIAGNOSTIC AND PREVENTATIVE CARE

I hereby authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits, to which I am entitled to Dr. _____. This assignment will remain in effect until revoked by me in writing. Photocopy of this assignment to be considered as valid as the original.

Patient Name Printed:_____

Patient or Guardian Signature:_____

Date: _____/_____/_____

Medical Insurance Card Information:

Name of Insurance: _____ **PPO / HMO / DMO**

Insurance Tel. #: _(____)_____-_____

Subscriber Name: _____

Subscriber D.O.B: _____/_____/_____

Enrollee ID #: _____