

New Smile Dentistry, PA

Family • Cosmetics • Implants

620 West State Road 434, Winter Springs, Florida 32708

(p): 407.327.0731 (t): 407.327.0731 (f): 407.327.1018

(e): info@NewSmileDentistry.net (w): www.NewSmileDentistry.net



Welcome to your new dental home! – Tell us about yourself.

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ DOB: _____ SSN: _____ []Male or []Female

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Marital Status: []Single []Married []Divorced []Widowed

Occupation: _____ Employer: _____

How did you hear about our office? - [] Friend/Family []Google []Insurance []Postcard []Other: _____

Primary Dental Insurance & Policy Holder Information

Policy Holder's Name: _____ P.H. DOB: _____ P.H. SSN: _____

P.H. Address: _____ P.H. Phone: _____

Policy Holder's Relationship to Patient: []Self []Spouse []Parent []Other: _____ P.H. Employer: _____

Insurance Company Name: _____ Ins. Co. Phone: _____

Ins. Co. Group Number: _____ Ins. Co. Member ID: _____

Insurance Authorization and Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have dental insurance coverage and authorize **New Smile Dentistry, P.A.** to submit claims for dental services provided. I assign directly to New Smile Dentistry, P.A. all insurance benefits otherwise payable to me for services rendered. I understand that I am **financially responsible for all charges**, whether or not they are covered or paid by my insurance company. I further agree to pay any balance not covered by insurance. I authorize the release of all information necessary, including dental and medical records, radiographs, treatment plans, and billing information, to my insurance company or its representatives for the purpose of processing and securing payment of claims. A copy of this authorization shall be considered as valid as the original. This authorization complies with the **Health Insurance Portability and Accountability Act (HIPAA)** and applicable **Florida privacy laws**. I understand that I have the right to revoke this authorization at any time in writing, except to the extent that action has already been taken based on this consent. I also authorize the use of this signature on all insurance submissions made by or on behalf of New Smile Dentistry, P.A.

Responsible Party Signature: _____ Relationship: []Self []Parent/Guardian

General Consent for Dental Care

I hereby consent to the performance of diagnostic procedures, examinations, and dental treatments by the dentists and clinical staff of **New Smile Dentistry, P.A.**, as may be necessary to provide proper dental care. I understand that dentistry is not an exact science and that no guarantees can be made regarding the results of treatment. I acknowledge that treatment outcomes depend in part on my own compliance with recommended care and instructions. I understand that the dentists and staff of New Smile Dentistry, P.A. are **not responsible for complications or treatment failures** resulting from my failure to follow professional advice, neglect of oral health, injury, or misuse of dental appliances.

Patient or Guardian Signature: _____ Date: _____

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Medical History

Do you have a primary care physician? No or Yes, if yes, when was your last visit to your PCP: _____

Physician's Name: _____ Physician's Phone: _____

Are you currently under the care of a physician for any reason? (Blood Pressure, Osteoporosis or Osteopenia, Heart Conditions, ect.)

Please explain: _____

Are you taking any medications regularly or receiving medications regularly at your physician office? No or Yes, if yes

please list: _____

Do you have or have you ever had any of the following?

YES	NO	CONDITIONS
-----	----	------------

- | | | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies-Seasonal |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy- date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes- Type I or Type II |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse- date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial/Jaw Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |

YES	NO	CONDITIONS
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- | | | |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV & AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacements- date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems-Dialysis or Disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy- date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | STD: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |

YES	NO	CONDITIONS
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- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke- date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |

YES	NO	ALLERGY/REACTIONS
-----	----	-------------------

- | | | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals/Jewelry |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

YES	NO	FOR FEMALES ONLY
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- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently Pregnant-
Weeks: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? |

Emergency Contact: _____ Phone: _____

I certify that the information I have provided on this medical history form is true and complete to the best of my knowledge. I understand that it is my responsibility to inform New Smile Dentistry, P.A. of any changes in my health, medical status, or medications at each visit. I acknowledge that providing accurate and updated information is necessary to ensure my safety and the safety of the dental team during my care.

Patient Signature: _____ Date: _____

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Dental History

Why are you needing to be seen today? Preventative Care (exams, x-rays & cleanings) or Emergency Pain

Are you currently in pain? No Yes, if yes where? (Upper/Lower & Left/Right?): _____

Date of Last Dental Visit: _____ Name & Ph of Previous Dentist: _____

How often do you brush? Once a day Twice a day After meals Other: _____

How often do you floss? Daily Occasionally Never

Do you require an antibiotic Pre-Medication prior to dental appointments? (ex: Joint replacement or Heart Conditions): _____

Do you have or ever had, or currently experiencing or have you experienced previously any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Sensitivity to hot or cold | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Orthodontic treatment (braces) |
| <input type="checkbox"/> Sensitivity to sweets or biting | <input type="checkbox"/> Frequent canker sores | <input type="checkbox"/> Periodontal (gum) treatment or deep cleaning |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Food trapped between teeth | <input type="checkbox"/> Oral surgery or extractions |
| <input type="checkbox"/> Bad breath / bad taste | <input type="checkbox"/> Broken fillings or crowns | <input type="checkbox"/> Root canal therapy |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Dental implants |
| <input type="checkbox"/> Jaw pain or clicking | <input type="checkbox"/> Dental anxiety | <input type="checkbox"/> Dentures or partials |
| <input type="checkbox"/> Difficulty opening or closing | <input type="checkbox"/> Gag Reflex during Dental Appts | <input type="checkbox"/> Cosmetic dentistry (veneers, whitening, bonding) |
- If yes, please explain: _____

Do you currently wear:

Nightguard Orthodontic Retainer Partial denture Full denture

Have you ever had a negative reaction to dental treatment or local anesthetic?

No Yes, If yes, please describe: _____

How do you feel about your smile?

I love it It's okay I'd like to improve it, what would it be? _____

Do you feel your teeth are:

Too dark Too short Crooked Chipped Other: _____

Are you happy with the color of your teeth?

Yes No Not sure

Are you happy with the shape and alignment of your teeth?

Yes No Not sure

Are you interested in learning more about:

- Teeth whitening
- Invisalign/clear aligners/Braces
- Dental implants
- Cosmetic smile options
- Replacing missing teeth

Final Statement of Truth

I certify that the information I have provided on this form is true and complete to the best of my knowledge. I understand it is my responsibility to inform **New Smile Dentistry** of any changes to my dental or medical history. This information is necessary to ensure safe and effective dental care for both myself and the dental team.

Patient Signature: _____ Date: _____

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Cancellation & Reschedule Policy

At New Smile Dentistry, your appointment time is **reserved exclusively for you**. Because we are a **private practice**, not a walk-in clinic, we carefully plan our schedule to give each patient the time and attention they deserve.

Our Commitment to You

We value your time and do our best to stay on schedule. Whenever possible, we schedule longer appointments so we can complete more of your treatment in one visit—making your care more efficient and minimizing disruptions to your day. However, **dental emergencies** can arise unexpectedly. If an emergency occurs, we will do our best to see that patient immediately—just as we would for you. We appreciate your patience and understanding if this ever causes a slight delay in your appointment.

Your Commitment to Us

As a courtesy, our office provides reminder calls, texts, or emails **1–2 days before your scheduled appointment**. **Please remember:** these reminders are a **courtesy**, not a requirement. It is your responsibility to know your scheduled appointment date and time. If you need to reschedule or cancel, please let us know **at least 2 business days in advance**. This allows us to offer your reserved time to another patient who may be waiting for care. If you arrive to your appointment more than 15 minutes late, we do reserve the right to reschedule the appointment with a \$50 broken appointment fee.

Late Cancellations & Missed Appointments

Appointments canceled with **less than 2 business days' notice** or **missed without notice (no-call, no-show)** will be subject to a **\$50 per hour of scheduled time** fee. We understand that life happens—if you have an emergency, please contact us as soon as possible so we can assist and make appropriate arrangements.

Questions?

If you have any questions about this policy or need to make changes to an upcoming appointment, please contact our team. We're always happy to help!

Patient Acknowledgment

I have read and understand New Smile Dentistry's Cancellation & Reschedule Policy. I agree to follow the guidelines outlined above.

Patient Signature: _____ Date: _____

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Financial Policy

1. Promise to Pay

You are responsible for payment of all dental services provided to you or your family members. By receiving treatment, you agree to pay all charges on your account according to the terms of this policy. If you have dental insurance, we will estimate your portion based on information provided by your insurance company. This is only an estimate — you are ultimately responsible for any balance not paid by your insurance. We will assist you in filing your dental insurance claim as a courtesy, provided that accurate and current insurance information is given **before** your appointment. If your insurance changes, please notify us at least **24 hours prior** to your visit.

Please note:

- We **do not accept or file medical insurance**.
- If you have a **secondary dental insurance**, you are responsible for payment based on your **primary insurance** only.
- Insurance is a **contract between you and your insurance company**. Our office is not a party to that contract.

2. Statements and Payments

You will receive a statement showing your account balance by mail, email, or text. Payment is due upon receipt unless your balance is noted as “pending insurance.” Once insurance payments are received, any remaining balance is your responsibility. If payment in full is not received within **30 days** of the statement date, a **Late Payment Fee of 5% per month** may be added to your unpaid balance, in accordance with Florida law.

3. Missed or Late-Cancelled Appointments

We reserve appointment times exclusively for each patient. To avoid a **Missed Appointment Fee**, please provide at least **48 hours’ notice** if you need to cancel or reschedule. Appointments cancelled or missed without proper notice may be subject to a **fee, \$50 per hour of appointment**.

4. Returned Payments

If a check or other payment method is returned by your bank as unpaid, a **Returned Payment Fee of \$45** will be charged to your account, consistent with allowable Florida banking fees.

5. Collections and Legal Costs

If your account remains unpaid and is referred to a collection agency or attorney, you may be responsible for **collection costs, court costs, and reasonable attorney’s fees**, as permitted under Florida law. We reserve the right to report late or unpaid accounts to credit reporting agencies. **Overdue Account Fee:** Accounts with balances unpaid after 90 days may be subject to a **reasonable administrative fee** of \$100-150 to cover additional billing and account management costs. This fee is applied **before an account is referred to an outside collection agency**. If your account is sent to a collection agency, you may also be responsible for any additional fees permitted by law. All fees, estimates and policies are disclosed at the time of treatment and acknowledged by the patient upon signing this agreement.

6. Credit Card Authorization

For your convenience and protection, **New Smile Dentistry, P.A.** may securely keep your credit card or CareCredit information on file. We may charge your stored payment method for any **outstanding or past-due balances**. A receipt will always be provided via text or email.

7. No Waiver

If we choose to waive any fee or policy term as a courtesy, it does not waive our right to enforce the same policy or fees in the future.

8. Contact for Billing Concerns

If you believe your billing or insurance information is incorrect, please contact us immediately via phone, text or email.

Acknowledgment and Agreement

I have read, understood, and agree to the terms of the **Financial Policy** above. I understand that I am financially responsible for all charges not covered by my insurance company and that payment is due as stated.

Patient Signature: _____ Date: _____

Responsible Party (if other than patient): _____ Name: _____

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HIPAA Acknowledgement & Patient Consent Form

Acknowledgement of Privacy Practices:

I acknowledge that I have received, reviewed, and understand the **Notice of Privacy Practices** of New Smile Dentistry, PA, which explains how my medical and dental information may be used and disclosed, and how I can access this information.

Consent to Use and Disclose Health Information:

I consent to the use and disclosure of my protected health information (PHI) by New Smile Dentistry, PA, for purposes of:

- Treatment and care coordination
- Payment of dental services
- Dental practice operations (including quality assessment and improvement activities, case management, and administrative activities)

I understand that my PHI may be shared with:

- My insurance company for claim processing
- Other healthcare providers involved in my care
- Authorized persons as allowed by law

Patient Rights:

I understand that:

- I have the right to review the Privacy Practices Notice before signing this consent.
- I may revoke this consent in writing at any time, except to the extent that the practice has already relied on it.
- I have the right to request restrictions on certain uses and disclosures of my PHI.

Communication Preferences:

I consent to the practice contacting me by the following methods (check all that apply):

- Phone call
- Text message
- Email

Acknowledgement and Agreement

By signing below, I acknowledge that I have read and understand this consent and HIPAA policies, and I agree to the use and disclosure of my health information as described above.

Patient Signature: _____ Date: _____

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General Dentistry Informed Consent – Acknowledgment of Risks

Please read each section carefully, and sign at the bottom. This form explains the potential risks associated with common dental procedures. **General Consent for Dental Procedures.** This general consent form covers the dental procedures that may be completed in our office. Signing and initialing this form **does not mean that any specific treatment is needed or will be performed.** By providing your consent, you are authorizing our dental team to diagnose and discuss any dental conditions, and to proceed with recommended treatment **only after** these conditions have been explained to you and you have agreed to the specific care. The procedures that may be diagnosed and discussed include, but are not limited to: Exams, X-rays, Cleanings, Fillings, Crowns, Root Canal Therapy, Bridges, Dentures, Extractions, Scaling & Root Planing, & Implants. **Please initial to acknowledge that this consent does *not* indicate that any of the above treatments are required or will be performed without your approval.** _____

1. General Understanding: I understand that all dental procedures—whether preventive, restorative, or surgical—carry some degree of risk, even when performed carefully and appropriately. No guarantees can be made regarding treatment outcomes.

2. Medications and Allergic Reactions: I understand that medications such as anesthetics, antibiotics, analgesics, and other drugs may cause allergic reactions or side effects, including redness, swelling, itching, nausea, vomiting, or, in rare cases, anaphylaxis.

3. Local Anesthetic Risks: I understand that local anesthetics may cause temporary or, rarely, permanent numbness, bruising, hematoma, soreness, or needle breakage. Rarely, anesthetic may contact nearby tissues or the eyes, causing irritation or temporary discomfort. On some occasions anesthetic can cause a Epinephrin reaction which can include but not limited to racing heart, sudden sweating, and light headedness/dizziness.

4. Changes During Treatment: I understand that unforeseen conditions may be discovered during dental procedures, and additional or alternative treatment may become necessary. I will be informed and consulted when possible.

5. Fillings and Restorations: I understand that fillings may cause temporary sensitivity or discomfort. Occasionally, deeper decay may require additional treatment such as a root canal or crown.

6. Crowns, and Bridges: I understand that it may not be possible to perfectly match the color of artificial teeth to natural teeth. Temporary restorations may loosen and require care. Delay in returning for permanent placement may result in tooth movement, requiring remake at additional cost.

7. Root Canal (Endodontic) Treatment: I understand that while root canal therapy aims to save a tooth, success is not guaranteed. Possible risks include pain, infection, instrument breakage, need for additional procedures (such as apicoectomy), or eventual tooth loss.

8. Tooth Removal (Extractions): I understand that removing teeth can involve risks such as pain, swelling, bleeding, infection, dry socket, sinus exposure, or jaw fracture. Temporary or permanent numbness or tingling may occur. Further treatment may be needed at my own expense if complications arise.

9. Periodontal (Gum) Conditions: I understand that gum disease involves bone and tissue loss that may lead to tooth loss if untreated. Dental procedures may temporarily aggravate gum conditions. Ongoing care and home hygiene are essential to manage the disease.

10. Dentures and Partial Dentures: I understand that adjusting to dentures can take time and may cause sore spots, speech changes, or difficulty eating. Immediate dentures often require multiple adjustments and future relines. Delayed appointments or failure to return may cause poor fit or the need for remake at additional cost.

11. Possible Soft Tissue or TMJ Discomfort: I understand that dental procedures may occasionally cause jaw soreness, joint discomfort (TMJ issues), or accidental injury to the tongue, lips, or cheeks. These are typically temporary but may require additional care.

12. Accidental Swallowing or Aspiration: I understand that small dental instruments or materials may rarely be swallowed or inhaled, possibly requiring medical evaluation or emergency care.

13. Medical History Disclosure: I understand that I must inform the dentist of all medications and health conditions. Certain medications (such as osteoporosis drugs like Fosamax®, Boniva®, Actonel®) can increase risk of complications, such as delayed healing of the jawbone or death of the bone.

14. Acknowledgment: I acknowledge that I have read and understood the potential risks of dental procedures. I have had the opportunity to ask questions, and all have been answered to my satisfaction. I understand that this form is for informational purposes only and **does not authorize or consent to specific treatment.**

Signature: _____ Printed Name: _____ Date: _____