NORTON SHORES FAMILY
DENTISTRY
THOMAS M. SMITH, D.D.S.
BLANE M. BOWEN, D.D.S.

Tel: (231) 780-5334
755 W. Seminole Rd, Suite 103
Muskegon, MI 49441

Office Hours:
M,T,Th 8:00-5:00
W&F 8:00-Noon

Welcome to our office! We are delighted to have you as a new patient and look forward to providing you with the highest quality dental care. With your commitment to appropriate recall/maintenance visits, costly dental work may be minimized. We will make every effort to keep your visits as comfortable as possible.

Financial Policy

Non-Coverage Payments are due in full at time of service. We do offer several payment options:

- All major credit cards
- Care Credit
- Cash
- Checks

Co-Payments vary based on your insurance provider and are also due at time of service.

Insurance

We provide insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) are dictated by the insurance company. In addition, certain insurance companies have an annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to us/your account. However, if you are paid by the insurance company instead of Dr. Thomas Smith, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You, as a patient, are always responsible for any insurance.

Rescheduled Appointments

We understand that there may be circumstances where you must reschedule an appointment. If you do need to reschedule, please do so as soon as you know that you will not be able to keep your appointment. Make sure to call at least 24 hours in advance.

Missed Appointments

If you miss an appointment, or cancel it with less than 24 hours notice, a missed appointment will be recorded in your file. If you are more than 15 minutes late for an appointment, a missed appointment will also be recorded in your file and you will need to reschedule.

If your record indicates that you have missed 2 or more appointments, a **$75.00 Non-Refundable** charge will be added to your account. This cancellation fee will have to be paid in-full on your next visit, or no dental services can be provided for you, with the exception of immediate emergencies.

I have read and fully understand the Dental Appointment Policy and agree to follow the terms set forth above.

Patient Name (Please Print) **Date**

Patient or Guardian Signature

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Thank you for selecting our dental healthcare team! To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information *(CONFIDENTIAL)*

Date _____

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

If you would like us to confirm your appointment by text or email please check an option: ☐ Email ☐ Cell Home Phone _____

Check Appropriate Box: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SS# _____

Is this person currently a patient in our office ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment

☐ Cash ☐ Personal Check ☐ Care Credit ☐ VISA ☐ MasterCard
☐ Discover ☐ AMEX

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____

Name of Employer _____ Work Phone _____

Employer Address _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

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 authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ _____

Signature of Patient or Parent if Minor Date

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Patient Dental History

Patient's Name _____ Date of Birth _____

1. Reason for this visit _____
2. When was your last dental visit _____ What was done then _____
3. How often did you visit the dentist before then _____
4. Have you had a complete series of dental films (X-rays) taken? When, where _____
5. How often do you brush your teeth _____ How often do you floss your teeth _____
6. Is your drinking water fluoridated _____

Do your gums bleed while brushing or flossing	☐ Yes	☐ No
Are your teeth sensitive to hot or cold liquids	☐ Yes	☐ No
Are your teeth sensitive to sweet or sour foods	☐ Yes	☐ No
Do you have a burning sensation on your tongue	☐ Yes	☐ No
Do you have dry mouth	☐ Yes	☐ No
Do you feel pain in any of your teeth	☐ Yes	☐ No
Do you have any sores or lumps in or near your mouth	☐ Yes	☐ No
Have you ever experienced any of the following problems with your jaw		
Clicking	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Difficulty in opening, closing or chewing	☐ Yes	☐ No
Do you have frequent headaches	☐ Yes	☐ No
Do you clench or grind your teeth	☐ Yes	☐ No
Do you bite your lips or cheeks frequently	☐ Yes	☐ No
Have you noticed any loosening of your teeth	☐ Yes	☐ No
Does food tend to become caught between your teeth	☐ Yes	☐ No
Have you ever had periodontal treatment (gums)	☐ Yes	☐ No
Have you ever had orthodontic treatment	☐ Yes	☐ No
Ever worn a bite plate or other appliance	☐ Yes	☐ No
Have you ever had any difficult extractions in the past	☐ Yes	☐ No
Have you ever had any prolonged bleeding following extractions	☐ Yes	☐ No
Do you wear dentures or partials	☐ Yes	☐ No
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	☐ Yes	☐ No

Please Flip Over

Are you under a physician's care now ☐ Yes ☐ No
If Yes _____
Have you ever been hospitalized or had a major operation ☐ Yes ☐ No
If Yes _____
Have you ever had a serious head or neck injury ☐ Yes ☐ No
If Yes _____
Are you taking any prescription or non prescription medications ☐ Yes ☐ No
If Yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates ☐ Yes ☐ No
If Yes _____
Are you on a special diet ☐ Yes ☐ No
Do you use tobacco/smokeless ☐ Yes ☐ No
Do you use controlled substances ☐ Yes ☐ No
If Yes _____
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ☐ Yes ☐ No

Women: Are you...
☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Have you ever had a reaction to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal ☐ Other _____
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Narcotics

Do you have, or have you had, any of the following

ADD/ADHD ☐ Yes ☐ No
AIDS/HIV Positive ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Angina ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No
Congentital Heart Disorder ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No
Dementia ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Drug Addiction ☐ Yes ☐ No
Eating Disorder ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Epilepsy or Seizures ☐ Yes ☐ No
Excessive Bleeding ☐ Yes ☐ No
Excessive Thirst ☐ Yes ☐ No
Fainting Spells/Dizziness ☐ Yes ☐ No
Gerd/Acid Reflux ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Heart Attack/Failure ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Heart Pacemaker ☐ Yes ☐ No
Heart Trouble/Disease ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Hepatitis A, B, C ☐ Yes ☐ No
Herpes ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
High/Low Blood Pressure ☐ Yes ☐ No
Hypoglycemia ☐ Yes ☐ No
Insomnia ☐ Yes ☐ No
Irregular Heartbeat ☐ Yes ☐ No
Kidney Problems ☐ Yes ☐ No
Leukemia ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Lung Disease ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No
Osteoporosis/Osteopenia ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No
Radiation Treatment ☐ Yes ☐ No
Recent Weight Loss ☐ Yes ☐ No
Renal Dialysis ☐ Yes ☐ No
Restless Leg Syndrome ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Rheumatism ☐ Yes ☐ No
Seasonal Allergies ☐ Yes ☐ No
Shingles ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
Snoring ☐ Yes ☐ No
Stomach/Intestinal Disease ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Tonsillitis ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Tumors of Growths ☐ Yes ☐ No
Thyroid Disease ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No
Veneral Disease ☐ Yes ☐ No

Have you ever had any serious illness not listed above ☐ Yes ☐ No If Yes _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

X _____ _____

Signature of Patient Date