*Global Smiles, Inc*
*Lilliana Stojic, DDS, MAGD, FICOI, LLSR*
*1801 Professional Drive, Sacramento, CA 95825*
*916-487-5147*

# Welcome to Global Smiles!

**So that we may better serve you, please indicate the purpose of your visit today:**

**Are you interested in any of the following services?**

- ☐ **Replacing missing teeth?**
- ☐ **Dental Implants?**
- ☐ **Straightening your teeth?**
- ☐ **Invisalign, the process of straightening your teeth without braces?**
- ☐ **Whitening your teeth?**
- ☐ **Closing spaces between your teeth?**
- ☐ **Changing the shape of your teeth?**
- ☐ **Fixing food trap areas?**
- ☐ **Conscious sedation dentistry?**

**Please circle your dental anxiety level.**

**(NO Problem) ◯1 ◯2 ◯3 ◯4 ◯5 (Fear Beyond Belief)**

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## PATIENT INFORMATION

**Please Print Legibly, Thank You.**

1. • _____ • _____ • _____ • _____
Patient's Last Name↑ First Name↑ Preferred First Name↑ M.I.↑

2. • _____ • _____ • _____ • _____
Mailing Address (include apartment #) City State Zip

3. • _____ • Sex: M F • _____ • _____ • _____
Patient DOB Social Security # Drivers License # State where Issued

4. • _____ • _____ • _____
Home # Cell # E-mail Address

5. • _____ • _____ • _____
Your Employer's Name Job Description/Title Work #

6. • _____ • _____ • _____ • _____
Employer's Address (include suite #) City State Zip

7. • _____ • _____ • _____
Person to Call in Case of Emergency Relationship Phone #

8. ☺ Who may we thank for referring you to our office? _____

## PRIMARY DENTAL INSURANCE INFORMATION

1. • _____ • _____ • _____ • _____
Insurance Company Name Ins. Phone # Group # Union #

2. • _____ • _____ • _____ • _____
Insurance Company Address City State Zip

3. • _____ • _____ • _____ • _____ _____ _____ Sex: M F
Policy Holder's Last Name First Name M.I. DOB

4. • _____ • _____ • _____ • _____
Policy Holder's Mailing Address City State Zip

5. • _____ • _____ • _____ • _____
Policy Holder's Home # Work # Cell # Policy Holder's Social Security #

6. • _____ • _____ • _____ • _____
Policy Holder's Employer Name Job Description/Title Drivers License # State where Issued

7. • _____ • _____ • _____ • _____
Policy Holder's Employer Address City State Zip

*I understand that regardless of my dental insurance status, I am ultimately responsible for the balance of my account for any professional services received. I certify the information that I have provided on this form is true. I will notify Global Smiles, Inc. of any changes in the above information as soon as I am aware.*

X _____ • _____
Signature of Patient (or Guardian if Under 18 Years of Age) Date

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# MEDICAL & DENTAL HISTORY

Patient Name: _____ Preferred Name: _____
Email: _____ Phone: _____

1. Are you currently under the care of a physician? ◯Yes ◯No Physician's Name: _____
   If yes, please explain: _____
2. Are you taking any prescription or over the counter drugs? ◯Yes ◯No
   If yes, please list each one: _____
3. Do you bleed excessively when injured? ◯Yes ◯No
4. **For Women**: Are you pregnant? ◯Yes ◯No Are you nursing? ◯Yes ◯No
   Are you currently taking birth control? ◯Yes ◯No
5. Please (check☑) either Yes or No for all conditions below that you have or have not had:

| | | |
|---|---|---|
| ◯Yes ◯No AIDS/HIV+ | ◯Yes ◯No *Pre-Med | ◯Yes ◯No High Blood Pressure |
| ◯Yes ◯No Arthritis | ◯Yes ◯No Pacemaker | ◯Yes ◯No Sinus Problems |
| ◯Yes ◯No Asthma | ◯Yes ◯No Liver Disease | ◯Yes ◯No Seizures |
| ◯Yes ◯No Stroke | ◯Yes ◯No Cancer | ◯Yes ◯No Kidney Problems |
| ◯Yes ◯No Vertigo | ◯Yes ◯No Diabetes | ◯Yes ◯No Low Blood Pressure |
| ◯Yes ◯No Tuberculosis | ◯Yes ◯No Hepatitis A/B/C | ◯Yes ◯No Rheumatic Fever |
| ◯Yes ◯No Heart Problem | ◯Yes ◯No Epilepsy | ◯Yes ◯No Other |

6. If you (checked☑) YES to Heart Problem or Other, please explain_____
   _____
7. Please (check☑) either Yes or No for all of the items listed below that you may or may not be allergic to:

| | | |
|---|---|---|
| ◯Yes ◯No Aspirin | ◯Yes ◯No Penicillin | ◯Yes ◯No Sulfa |
| ◯Yes ◯No Erythromycin | ◯Yes ◯No Tetracycline | ◯Yes ◯No Dental Anesthetic |
| ◯Yes ◯No Codeine | ◯Yes ◯No Latex Gloves | ◯Yes ◯No Acetaminophen |
| ◯Yes ◯No Metals (Jewelry) | ◯Yes ◯No Ibuprofen | ◯Yes ◯No Other |

8. Please list any other allergies:_____
9. What was your previous dentist's name?_____Date of last visit?_____
10. Have you ever had Periodontal corrections; for example: Gum surgery/ Root Planing/ Deep Cleaning. ◯Yes ◯No.
11. Have you ever had Orthodontic appliances/ Braces/ etc.? ◯Yes ◯No.
12. Do your gums bleed after brushing or flossing? ◯Yes ◯No
13. Do you smoke or chew tobacco? ◯Yes ◯No If yes, how much and/or often?_____
14. Have you ever taken medication for Osteoporosis? ◯Yes ◯No If yes, what?_____
15. Have you had any type of implant placed or joint replacement ◯Yes ◯No If yes, what? _____

## TREATMENT CONSENT

The answers that I have provided are true to the best of my knowledge. In addition, I authorize the doctors and staff of Global Smiles to provide me with routine dental care including but not limited to radiographs, photographs, diagnostic, prophylactic, preventative and restorative dental procedures.

X_____Date _____

Signature of Patient (or Guardian if the patient is under 18 years of age)

Doctor's Signature: _____ Date _____

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# Assignment of Benefits Form

**Patient Name:** _____

I hereby instruct and direct my dental insurance provider to pay my dentist (Global Smiles) for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered; by check, made out and mailed to:

**Dr. Lilliana Stojic, DDS**
**1801 Professional Drive**
**Sacramento, CA 95825**

If my current policy prohibits direct payment to my dental provider, I hereby instruct and direct my dental insurance provider to make the check out to me and mail it to the following address:

**Dr. Lilliana Stojic, DDS**
**1801 Professional Drive**
**Sacramento, CA 95825**

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. The insurance payment(s) will not exceed my indebtedness to Global Smiles, and I have agreed to pay any balance of professional service charges over, above, and not covered by the insurance payment(s).

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the release of my personal information to any insurance company, adjuster, or attorney involved with my dental care.

If necessary, I authorize Global Smiles to initiate a complaint to the State Insurance Commissioner(s) for any reason on my behalf.

Signed at (City)_____on (Date) _____

X_____
Signature of Patient (or Guardian if Under 18 Years of Age)

X_____
Witness

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# OFFICE POLICY

**PATIENTS WITH DENTAL INSURANCE:**
As a courtesy to you, our office will gladly submit rendered services to your insurance. We are able to bill to all traditional insurance plans. We **DO NOT** participate with DMO or HMO plans. Under these plans, there is **NO COVERAGE** when treatment is rendered by a non-participating dentist. Please check your type of plan carefully. **PATIENTS WITH DELTA DENTAL INSURANCE:** Dr. Stojic is a "**PREMIER"** provider (not PPO). However, we are still able to bill your insurance for all PPO plans, even though Dr. Stojic is out-of-network. **(Initial_____)**

**AUTHORIZATION TO RELEASE INFO AND ASSIGNMENT OF BENEFITS:**
I certify that I (**Name: _____),** (or my dependent) have(has) dental insurance coverage and assign directly to Dr. Lilliana Stojic all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or his staff to release all necessary personal information to my insurance company in order to secure the payment benefits. **(Initial_____)**

**PAYMENTS:** We accept cash, check, Visa, MasterCard, and Discover. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot *guarantee* the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office policy does not allow partial payments. If a credit balance should result after insurance processes your claim, a refund will be promptly issued to you. **(Initial_____)**

**UNPAID INSURANCE CLAIMS:**
All dental services rendered, whether or not covered by your insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, the balance will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive payment from your insurance after it has been paid by you, a prompt refund will be issued **(Initial_____)**

**PAST DUE ACCOUNTS:** If payment is not received by the due date printed on the statement, then your account is considered "past due". We reserve the right to charge a $10.00 per month billing charge on all past due accounts. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collections agency and/or our attorney for collection, the account holder will be responsible for ALL attorney fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder. **(Initial_____)**

**PATIENTS WITHOUT DENTAL INSURANCE:** Payment in full is expected at the time services are rendered. We accept cash, check, Visa, Mastercard, and Discover. **(Initial_____)**

**BROKEN/MISSED APPOINTMENTS:** We request at least 48 business hours' notice before cancelling or rescheduling an appointment. Less than 48 business hours make it difficult for us to fill the opening left in our schedule. Friday, Saturday and Sundays are not considered business hours. We reserve the right to charge your account $50 per hour reserved for the appointment if not notified. **(Initial_____)**

Dr. Lilliana reserves the right to update and make changes the above-stated office policies at any time without prior notification.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Patient Name (print): _____ Date: _____

Signature: _____ Relationship to patient: _____

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# OFFICE FINANCIAL POLICY

We strive to provide the best dental care for our patients and try to take into consideration all circumstances involving each patient and their ability to receive their needed dental care. To provide our patients with this level of quality care, we will be asking you to pay your estimated patient portion at the time of treatment. This will enable us to keep our fees reasonable for all patients by limiting the expense of billing patients for treatment rendered.

We do our best to estimate your insurance, however if there is a balance due after your insurance company pays their portion, you will be billed for any amount still due as you are responsible for any charges exceeding your benefits. Should your unpaid balance be over 90 days, finance charges will accrue at 18% annual interest.

We accept all major credit cards and debit cards. We also subscribe to Care Credit, which is a healthcare financing service.

Based on the information we have from you about your insurance, we will provide you with an estimate of your expected portion for the treatment needed. Please keep in mind that treatment may change as services are rendered. Some teeth may have hidden decay, or affected nerves, requiring more extensive dental treatment or additional charges. You will be informed of any changes at the time of your appointment.

Treatment estimates are ONLY an ESTIMATE. Insurance estimates are only an ESTIMATE and not a guarantee of payment by your insurance company. Ultimately you are responsible for all fees including those not paid by your insurance.

## MISSED APPOINTMENTS

Providing excellent dental care for my patients is of utmost importance to my staff and me. In order for us to provide you with this quality of care, it is necessary for you to honor the appointments that you schedule. In this busy society, schedules change from day to day, and we certainly understand this. All we ask is that you call the office 48 hours in advance to cancel the appointment. We have patients waiting for certain appointment times and if we receive advance notice, we will be able to contact these patients so they may have their dental work completed. If there are multiple missed appointments, you may be charged up to $250 for the appointment time.

By signing below you are agreeing to the above policies.

_____

Patient or Guardian Signature Date