Super Smiles
54 Middlesex Turnpike
Suite 104
Burlington, MA 01803
781.272.1288
www.supersmilesburlington.com

General Office, Financial, Cancellation Policy

WELCOME

We are pleased to welcome you to Super Smiles for your dental care.

Your first appointment will consist of a comprehensive oral exam. Dr. Miller will review your medical and dental history, explain your dental diagnosis and present your treatment options.
Initial dental evaluations are commonly completed with a full set of dental radiographs (X-rays). You may request a set of your radiographs to be forwarded to our office if they were taken within the last six months. If additional films are necessary, they can be taken at our facility.

We appreciate your assistance in providing us with the following information on the day of your appointment:

1. Radiographs (x-rays) if applicable
2. A list of your current medical prescriptions. Please inform our office if you have any medical conditions that may be of concern prior to dental treatment (i.e. high blood pressure, previous heart surgery, allergies to medicine, etc.)
3. Your dental insurance information

Medical History Information

In order to ensure your safety, it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicine you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any drug allergies you have.

Minors

We must receive written consent prior to performing any non-emergency dental procedures on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures, unless they have been given written consent by the parent or legal guardian. Please do not send your child to an appointment alone or with someone other than yourself, unless you have filled out any necessary consent forms prior to the appointment, otherwise we must reschedule your child's appointment to another day.

Requests for records/radiographs (x-rays)

By law we are required to keep a patient's original radiographs and record in this office. Original images or records will not be released without a patient's consent. The patient or a designated person may request copies of their radiographs or record by signing a record release form. There is a $15 fee for each copy. There is no fee to send radiographs to a specialist that we refer you to.

FINANCIAL POLICY

Our primary goal is to not allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. We are dedicated to providing with care that is both effective and affordable. Our fees

are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary fee for our area. We accept the following forms of payment: Cash, Money Order, Visa, MasterCard and Discover. We do not accept personal checks. If you are interested in financing options, we participate with Care Credit and Lending Club. These are patient payment programs offering a full range of No Interest and Extended Payment Plans for treatment fees from 1$ and up. **Payment for services is due at the time services are rendered.**
We are happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at anytime to discuss any concerns you may have.

Dental Insurance: In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. If you have dental insurance, we ask that you provide all requested information to allow us to assist you in the benefit verification process before treatment and to help you calculate your costs and maximize your insurance. You are however responsible for understanding your own dental insurance policy.
We submit the claims necessary to see that you receive the full benefit of your coverage as a courtesy to our patients. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We do not guarantee what your insurance will or will not pay for each claim. Ultimately, you are responsible for payment. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health.

DEPOSIT POLICY

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for reservations over 2 hours, we require a deposit amount of half of the treatment fee to make your reservation.

CREDITS AND REFUNDS

In the event of a credit balance on your account, those credit balances will be applied to future visits within the next 90 days. If not applied in that time period, credit balances of $15 or more will be mailed to the address on record. We ask that you ensure we have up to date contact information on file. Credit balances of less than $15 will be held on the account until applied to a visit or refunded at your request by check only.

CANCELLATION POLICY FOR NON COVID RELATED REASONS

Our practice is dedicated to quality care and exceptional service. The staff at Super Smiles spends extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as our other patients. We require that you confirm by email or phone to reserve your appointment with Dr Miller.

If cancellation is necessary, we require that you call at least 48 hours notice in advance.
Appointments are in high demand and your advanced notice will allow another patient access to that appointment time. If you need to cancel your appointment, please call us at (781) 272-1288

between the hours of 9am – 6pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

If you cancel less than 48 hours before your appointment or do not show to your appointment without notice, you will be subject to a $40.00 cancellation fee. We understand unexpected events may affect your schedule. Therefore, we apply the three strike rule: after the third missed appointment without proper notification, you will be formally and permanently dismissed from our office. Additionally, if applicable, MassHealth insurance plan requires that we report any broken appointments to their system. MassHealth may revoke insurance coverage if an excessive number of broken appointments are reported.

Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication, and we look forward to continuing that relationship with you.

Thank you for understanding our General Office, Financial and Cancellation Policy.
We look forward to taking care of all your dental needs.

I have read and agree to the General Office Policy, Financial Policy and the Cancellation Policy of Super Smiles.

_____ _____

Signature of Patient or Guardian Date

General Dentistry Informed Consent

Dr. Emilie Miller will perform a complete evaluation of your dental condition. You consent to perform whatever is deemed necessary to diagnose and treat what has been planned. These may include the use of digital radiographs (x-rays), local anesthesia and other medications. You will be advised of the options for treatment and will have the opportunity to ask any questions. You, the patient, have a right to accept or reject dental treatment proposed by Dr. Miller. You should carefully consider the anticipated benefits and common known risks of the recommended procedures, alternative treatment or the option of no treatment.

Medical History Information
In order to ensure your safety, it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicine you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any drug allergies you have.

Digital radiographs and photos
Modern dental radiograph equipment uses extremely low-dose radiation. Diagnostic radiographs provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum images necessary to allow us to do a thorough exam for each patient. All patients 18 years and older will receive a full mouth series of intra-oral digital radiographs. Without these images, we cannot complete an exam of the entire mouth and jaw. We also take photos of our patients as part of their permanent record. These images are stored in a secure manner that will protect your privacy and they will be kept for the time period required by state law. We will not release these photos to anyone without your written permission.

Complications
Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on rare occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe. Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.

Specific Problem Examinations
In the event that a patient requests only a specific problem be addressed (i.e.: broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. The appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a complete exam.

Specialty Referral and/or Second Opinion
General dentists perform the majority of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics,

periodontics, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I request and authorize. I have the opportunity to ask questions and have my questions answered to my satisfaction.

I hereby authorize the dental staff of Super Smiles to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation. I consent to allow Super Smiles to take x-rays and perform an examination on me today.

_____ _____
Signature of Patient or Guardian Date

NOTICE OF PRIVACY PRACTICES

I have reviewed the offices Notice of Privacy Practice and I understand that I may request a copy for my records.

_____ _____
Signature of Patient or Guardian Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

I give permission to discuss health information with the following person (print name if opting in):

_____

_____

Super Smiles Dental
54 Middlesex Turnpike
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(781) 272-1288

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

For office use only:

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years Preferred Appointments _____

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

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

Whom may we thank for referring you? _____ What's the best way to reach you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

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

Address _____ Home Phone _____

Birthdate _____ Currently a patient in our office? ☐ Yes ☐ No

Employer _____ Work Phone _____

E-Mail _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have or have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collecting between the teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Have you ever had any serious illnesses or operations?? ☐Yes ☐No If yes, describe _____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates _____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check (✓) if you have or have had problems with any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Anemia	☐	☐	Congenital Heart lesions	☐	☐	Hepititis	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cortisone Treatments	☐	☐	Hernia Repair	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Skin Rash
☐	☐	Artificial Joints, Pins, etc.	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Swelling of Feet or Ankles
☐	☐	Back Problems	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Bleeding Abnormally	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Rheumatic fever			

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Local Anesthetic	☐	☐	Iodine	☐	☐	Other _____
☐	☐	Barbiturates (Sleeping Pills)	☐	☐	Penicillin	☐	☐	Latex			_____
☐	☐	Codeine	☐	☐	Sulfa	☐	☐	None			

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

_____ _____

Signature of of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.