

# Marina Tooth Fairy

*Creating healthy, beautiful  
smiles for all ages!*



## OUR POLICIES

WELCOME to the Marina Tooth Fairy! It is our pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations. If you have dental insurance, we will be glad to help you to receive your maximum allowable benefits.

The following is our office payment policy

- Payment is due at the time services are rendered. We accept Cash, Checks, MasterCard, and Visa.
- If you are a patient with insurance, it is important to remember that your insurance plan is a contract between you, your employer, and the insurance company. The contract is in no way a binding obligation between the Dental Insurance Company and Marina Tooth Fairy.
- Our fees generally fall within the acceptable range of the maximum allowance determined by each insurance carrier. This applies only to companies, which pay a percentage of “Usual, Customary, and Reasonable,” rates. This does not apply to companies, which reimburse based on an arbitrary “schedule” of fees.
- After your initial exam you will receive a treatment plan which estimates your portion of payment. If we estimate and collect your co-payment and the insurance underpays or denies a benefit, you are responsible for the remaining balance.
- While discouraged, a submitted insurance pre-estimate may be sent to your insurance company if you request this. The fee for this pre-estimate is \$50.00.
- Not all services are covered in all insurance contracts. Insurance companies arbitrarily select certain procedures they do not cover, based upon the premium/contract arranged by your employer.
- In order for to help you process your insurance claim for your reimbursement, please bring all insurance information with you. Also, please call your dental insurance carrier to expedite claims if a claim is not paid within 30 days, as the law requires.

Returned checks and outstanding balances over 60 days are subject to collections fees and an interest rate charge of 1.75% per month. There is also a charge for broken appointments and those canceled without 48 hours notice. Please remember that the staff sets aside a designated amount of time for your particular type of treatment. If you miss an appointment without notifying our office, you will be required to pay 50% of the value of your next appointment (nonrefundable) before scheduling. If you miss two scheduled appointments without notifying our office, you will be dismissed. We appreciate your understanding of how important keeping appointments is to the doctor and our other patients. We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information or insurance coverage, please do not hesitate to ask...we are here to help!

Patient signature

date



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## MEDICAL HISTORY

Medical history for  
(Your medical history is confidential and necessary for our files and for your health.)

## GENERAL INFORMATION

yes      no

Is your health good?

Has there been a change in your health within the last year?

Have you been hospitalized or had a serious illness?

If so, please explain below.

Date of last medical exam                      Date of last dental exam

Are you being treated by a physician now?

For what?

Your physician's name

Physician's phone

## HAVE YOU EXPERIENCED ANY OF THE FOLLOWING

yes      no

chest pain (Angina)

swollen ankles

shortness of breath

joint pain, TMJ syndrome

persistent cough, coughing up blood

bleeding problems, bruising easily

sinus problems

frequent vomiting, nausea

jaundice

yes      no

dizziness

headache

ringing in ears

fainting spells

difficulty urinating, blood in urine

seizures

excessive thirst

dry mouth

## DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

yes      no

heart disease

heart attack, heart defects

heart murmurs

rheumatic fever

blood disorder (sickle cell/hemophilia)

stroke, hardening of arteries

high blood pressure

diabetes

TB, emphysema, or other lung diseases

hepatitis A or B, or other liver diseases

stomach problems, ulcers

allergies to drugs, food or medications

If any, please explain

yes      no

broken bones

AIDS or HIV+

eye diseases

skin diseases

anemia

herpes

VD (syphilis or gonorrhea)

cold sores or fever blisters

kidney, bladder disease

thyroid, adrenal disease

tumors/cancer

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## DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

yes      no

psychiatric care  
radiation treatments  
chemotherapy  
prosthetic heart valve  
artificial joint or pins  
contact lenses

yes      no

hospitalization  
blood transfusions  
surgeries (If any, please explain below)

pacemaker

## ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING

yes      no

recreational drugs. If so, which types?  
drugs, medicines. If so, which types?  
tobacco in any form. If so, how much and for how long?  
alcohol. If so, how much and how often?  
redox or fen fen

Do you have any or have you had any other diseases or medical problems not listed on this form?  
If so, please explain.

## QUESTIONS FOR WOMEN

yes      no

Are you,/could you be pregnant or nursing?  
If pregnant, how many months?  
Are you taking birth control pills? Type and dose?

## SMILE DESIGN

yes      no

Are you satisfied with the appearance of your teeth?  
Would you like a whiter smile?  
Have you had orthodontic (braces) treatment?  
Would you like straighter teeth?

To the best of my knowledge, I have answered every question on this form completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient signature

date