Smile Dental care

WELCOME TO SMILE DENTAL

LAST NAME: _____FIRST NAME:_____MI:_____

CIRCLE ONE : M OR F CHECK ONE: MARRIED___SINGLE___CHILD___OTHER_____

AGE:_____BRITHDATE:_____SOCIAL SECURITY #:_____

ADDRESS:_____

CITY:_____STATE:_____ZIPCODE:_____

PHONE#:_____CELL PHONE:_____EMAIL:_____

EMPLOYER:_____BUSINESS PHONE:_____

EMERGENCY CONTACT:_____PHONE#:_____RELATIONSHIP:_____

PRIMARY DOCTOR:_____PHONE#:_____

PHARMACY NAME:_____ PHARMACY LOCATION:_____

DENTAL HISTORY:

DATE OF LAST COMPLETE DENTAL EXAM:_____

WHAT PROBLEMS ARE YOU HAVING NOW?(DESCRIBE)_____

_____

DO YOU WEAR DENTURES ? Y OR N FULL?_____ PARTIAL?_____ HOW OLD ARE THEY?_____

ARE YOU APPREHENSIVE ABOUT DENTAL TREATMENT? Y OR N

DO YOUR GUMS FEEL TENDER OR BLEED EASILY? YES OR NO HOW LONG?_____

ARE YOU SENSITIVE TO: HOT COLD SWEETS PRESSURE (PLEASE CIRCLE ALL THAT APPLIES)

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

HEART DISEASE/ATTACK	ARTIFICIAL JOINTS	BLOOD TRANSFUSION	SINUS TROUBLE
ANGINA PECTORIS	ANEMIA	DRUG ADDCTION/ALCOHOLISM	THYROID DISEASE
HIGH BLOOD PRESSURE	STROKE	HEMOPHILIA	HAY FEVER
HEART MURMUR	KIDNEY TROUBLE	FEVER BLISTERS	HIGH CHOLESTROL
RHEUMATIC FEVER	ULCERS	EPILEPSY	ARTHRIIS
CONGENITAL HEART LESION	HIV/AIDS	PSYCHIATRIC TREATMENT	ASTHAMA
MITRAL VALVE PROLAPSE	HEP A	GLAUCOMA	ALLERGIES / HIVES
ARTIFICIAL HEART VALVE	HEP B	HEART PACEMAKER	DIABETES
CHEMOTHERAPY / RADIATION	HEP C	CANCER	LATEX ALLERGY
HEART SURGERY	STD	EMPHYSEMA	PENICILLIN ALLERGY

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW?_____

WHAT ARE YOU CURRENTLY BEING TREATED FOR ?_____

DO YOU REQUIRE ANTIBIOTIC PROPHYLAXIIS? _____WHY?_____

ARE YOU TAKING BLOOD THINNERS SUCH AS COUMADIN, ASPIRIN OR PLAVIX?_____

LIST CURRENT MEDICATIONS:_____

ARE YOU PREGNANT? YES OR NO ARE YOU ALLERGIC TO ANY MEDICATIONS?_____

HAVE YOU EVER HAD ANY ADVERSE REACTION TO LOCAL ANESTHETICS?_____

ARE YOU TAKING ANY ANTIOSTEOPOROSIS MEDICATIONS(FOSAMAX. ETC)_____

PLEASE LIST ANY OTHE KNOW ALLERGIES_____

PATIENT SIGNATURE:_____DATE:_____

INSURANCE INFORMATION

NOTE: the following information pertains to the individual who is the primary subscriber of the insurance policy. it also pertains to the parent guardian when the patient is under the age of 18.

INSURANCE POLICY HOLDER INFORMATION PARENT OR LEGAL GUARDIAN (IF PATIENT IS A MINOR)

LAST NAME: _____FIRST NAME:_____MI:_____
CIRCLE ONE : M OR F CHECK ONE: MARRIED___SINGLE___CHILD___OTHER_____
AGE:_____BRITHDATE:_____SOCIAL SECURITY #:_____
ADDRESS:_____
CITY:_____STATE:_____ZIPCODE:_____
PHONE#:_____CELL PHONE:_____EMAIL:_____
EMPLOYER:_____BUSINESS PHONE:_____

NAME OF PATIENTS INSURANCE CARRIER:_____

ADDRESS:_____
CITY:_____STATE:_____ZIPCODE:_____
GROUP NUMBER: _____PHONE#:_____

SECONDARY INSURANCE:_____GROUP OR ID #_____

FINANCIAL POLICY/ AUTHORIZATION

I have received the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the Dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the Dentist as soon as possible

I authorize the insurance company indicate don this form to pay the Dentist all insurance benefits otherwise payable to n=me for the services rendered. I authorize the use of this signature on all insurance submissions.

I understand that the office will try to calculate my percentage of payment due at the time of the service as close as possible. Example: the deductible, copayment and annual maximum per calendar year. I understand that in the event that there is a remaining amount not paid by the insurance I will receive a billing statement which would be due for payment to the dental office. I understand that in the event the balance becomes over 90 days past due my account may be forwarded to a collections agency.

I authorize the Dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance and that payment are due at the time of the treatment, unless prior arrangements have been made.

Signature:_____date:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?:

NEWSPAPER FLYERS BROCHURE POSTERS FRIEND RELATIVE

OTHER: (PLEASE SPECIFY):_____

Smile Dental care

DENTAL TREATMENT CONSENT FORM

please read and initial items checked below. Also read and sign at the bottom of the form.

Patient name _____Birthdate_____

1. ***Work to be done***
   I understand that I may have the following work done: Fillings_____ Bridges_____ Crowns_____ Extractions____ Impacted teeth removed_____ General Anesthesia____ Root Canals____ Others_____ ***Initials:_____)***
2. ***Drugs and administration***
   I understand that antibiotics or analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and or anaphylactic shock (severe allergic reaction). ***(Initials:_____)***
3. ***Changes in treatment plan***
   I understand that during treatment it may be necessary to change or add procedure because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. ***(Initials:_____)***
4. ***Removal of teeth***
   I understand the removing of teeth does not always remove all the infection. I f present and it may be necessary to have further treatment. I understand the risks involved in having the teeth removed. some if which are in pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips , tongue and surrounding tissue that can last for an indefinite period of time(days or moths) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. ***(Initials:_____)***
5. ***Crowns and Bridges***
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns. which may come off easily and that I must be careful to ensure that they are kept on until the permanent crows are delivered. I realize the final opportunity to make changes in my new crown or bridge will be before cementation. ***(Initials:_____)***
6. ***Dentures, Complete or Partial***
   I realize that full or partial dentures are artificial, constructed of plastic, metal and /or porcelain. I realize the final opportunity to make changes in my new dentures will be the "teeth in wax" try I visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee. ***(Initials:_____)***
7. ***Endodontic Treatment (Root Canal)***
   I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extent through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment.(apicoectomy). ***(Initials:_____)***
8. ***Periodontal loss (Tissue & Bone)***
   I understand that I may have a serious condition causing gum and bone infection or bone loss and that it can lead to loss of my teeth. I understand that any dental procedure may have a future adverse effect on my periodontal condition. ***(Initials:_____)***

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by any one regarding the dental treatment which I have requested and authorized for myself or my minor child or a minor for whom I am a legal guardian.

Signature of patient or legal guardian_____ date_____

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

***You may refuse to sign this acknowledgement**

I _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

PRINT NAME **DATE**

_____

SIGN NAME

FOR OFFICE USE ONLY

We attempted to obtain a written acknowledgement of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other(Please specify)

FOR ALL PATIENTS TO READ:

PAYMENT POLICY:

1. Payment is due at the time services are rendered.
2. For patients with insurance; any co-payments and deductibles are also due on the day services are rendered. (We calculate these to the best of our abilities, there may be an additional charge after the insurance has paid- as we have previously stated, this is only an estimate.)
3. If you have any questions or need estimates, please feel free to ask us at any time.
4. **PATIENTS ARE RESPONSIBLE FOR ANY BALANCE ON THEIR ACCOUNT IF YOUR INSURANCE DENIES PAYMENT.**

PLEASE NOTE: For patients with insurance: IT IS YOUR RESPONSIBILITY to know your insurance plan. As a courtesy, our office tries to inform patients in advance of any co-payments that may be due. However, we are not always able to discuss this with the patient before their visit.

Also please note: There is an x-ray duplication fee, if you ever request a copy of your x-rays there is a non- refundable $25.00 duplication fee.

IF YOU ARE UNSURE OF CO-PAYMENTS/PAYMENTS DUE, PLEASE ASK!!!!!

_____ _____

PATIENT SIGNATURE **DATE**

*******if patient is under 18 years old, parent/guardian signature is required*******

To all of our valued patients:

Recently it has come to our attention that some of our patients have been not coming to their scheduled appointments. As this is becoming a more and more frequent problem we are implementing the following office procedure: if you no show for three appointments, we will be forced to dismiss you from the practice. You will first be given a verbal warning, then a written and finally a dismissal letter. We understand this is an inconvenience for you, but is for us as well. Please sign below that you stand what you have read and agree to our new office procedure.

Thank you for understanding and consideration on this matter.

Patient signature **Date**

HIPAA NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law.

It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you.

For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

2. Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

3. Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that se patients at our office.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable 1Du Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates:

4. Required Uses and Disclosures:

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations.

You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes.

You then have the right to object or withdraw as provided in this notice. Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on or before April 14. 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.