# Smile Centers PC

PATIENT INFORMATION

DATE ___________________

NAME :_______________________________ HOME TEL # _____________________________

ADDRESS: _________________________________________________________________________________

BIRTH DATE: ___________________ SSN# ____________________ DRIVER'S LIC # ______________________

EMPLOYER ____________________________________ WORK TEL # _________________________________

EMPOYER'S ADDRESS: _______________________________________________________________________

DENTAL INSURANCE COMPANY: _________________________________ GROUP # ______________________

Has any member of your family been treated in our office? Yes_________ No________

Whom may we thank for referring you to our office? ____________________________________________________

Most convenient appointment time? ____________________________________________

FAMILY INFORMATION:

SPOUSE NAME: ___________________________ BIRTH DATE: _____________ SSN# ____________________

ADDRESS: _________________________________________________________________________________

EMPLOYER: __________________________________ HOME TEL # ___________________________________

EMPLOYER'S ADDRESS: _______________________________________ WORK TEL# _____________________

DENTAL INSURANCE COMPANY: ______________________________________ GROUP# __________________

PERSON RESPONSIBLE FOR ACCOUNT: ________PATIENT _________FATHER OR HUSBAND

________GUARDIAN _________MOTHER OR WIFE

PERSON TO CONTACT IN CASE OF EMERGENCY: Name: ___________________________________________

ADDRESS: _____________________________________________ TEL# _______________________________

METHOD OF PAYMENT:

Does responsible party currently have an account with this office? Yes____________ No________________

If NO, please check the method of payment for your first visit: CASH __________ CHECK ____________

Note: If you have dental insurance, it may be used in future visits to help with the cost of treatment.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any balance not paid by your insurance. If we agreed to wait for said insurance monies and reimbursement is short of what is expected, then you are responsible to pay it. Your cooperation in this matter helps control our costs.

AUTHORIZATION:

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of the patient's record and any information necessary. I hereby assign all Dental Benefits to **Smile Centers PC.** This assignment and that for credit card billing will remain in effect until revoked by me in writing. A photocopy of this assignment and authorization is considered to be valid as an original. I understand that I am financially responsible for all charges Whether or not paid by insurance. The information on this page is correct to the best of my knowledge.

SIGNED _______________________________________________ DATE: ______________________________

RESPONSIBLE PARTY: ____________________________________ DATE:_______________________________

# HEALTH HISTORY

Patient's Name          Date of Birth          Date

**Answer all questions by circling Yes (Y) or No (N)**          **All responses are kept confidential**

1. Are you in good health?........................................ Y N
2. Has there been any change in your general health in the past year? ........................ Y N
3. Date of last physical exam ____________________
4. Are you now under a physician's care for a particular problem?........................................ Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:............ Y N
   ____________________________________________
   ____________________________________________
6. Height ______ Weight ______
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   B. Congenital Heart Disease?.................................... Y N
   C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?)................................ Y N
   D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?........................................................ Y N
   E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness........................................................ Y N
   F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ........... Y N
   G. Liver Disease (Jaundice, Hepatitis)?...................... Y N
   H. Kidney Disease? ................................................ Y N
   I. Diabetes? ........................................................... Y N
   J. Thyroid Disease (Goiter)? .................................... Y N
   K. Arthritis? ............................................................ Y N
   L. Stomach Ulcers or Colitis? .................................... Y N
   M. Glaucoma?.......................................................... Y N
   N. Osteoporosis ...................................................... Y N
   O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ................. Y N
   O. Radiation (X-ray) treatment for Cancer? ............... Y N
   P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   Q. Sinus or Nasal problems? ..................................... Y N
   R. Any disease, drug or transplant operation that has depressed your immune system?............ Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   A. Antibiotics?......................................................... Y N
   B. Anticoagulants (Blood Thinners)? .......................... Y N
   C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   D. High Blood Pressure medications? ........................ Y N
   E. Steroids (Cortisone, etc.)?..................................... Y N
   F. Tranquilizers ....................................................... Y N
   G. Insulin or Oral Anti-Diabetic drugs?........................ Y N
   H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa) ? ........................................................ Y N
   J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:____________________________________
   ____________________________________________
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   A. Local Anesthesia (Novocain, etc.)?........................ Y N
   B. Penicillin or other antibiotics?................................ Y N
   C. Sedatives, Barbiturates? ....................................... Y N
   D. Aspirin or Ibuprofen?............................................. Y N
   E. Codeine or other pain killers?................................. Y N
   F. Latex or Rubber Products? .................................... Y N
   G. Other allergies or reactions? Please, list............... Y N
   ____________________________________________
   ____________________________________________
10. Do you smoke or chew Tobacco? ................................ Y N
    How much per day? _________
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ............................................. Y N
12. Have you had any serious problems associated with any previous dental treatment? .................................... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ........ Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ...................................................... Y N
15. Do you wish to talk to the doctor privately about anything?............................................................ Y N
16. **FOR WOMEN ONLY**
    A. Are you Pregnant, or **is there any chance** you might be Pregnant? ........................................ Y N
    B. Are you nursing? ................................................... Y N
    C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

**I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.**

| Date | Signature of Person Completing Health History | Doctor's Initials |
|---|---|---|

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**Medical Update:** I have ready my Health History dated ____________________ and confirm that it adequately states past and present conditions.

| Date | Exceptions or changes | Patient's Signature | Doctor's Initials |
|---|---|---|---|
| Date | Exceptions or changes | Patient's Signature | Doctor's Initials |

**Dental History:**

1. Reason For Present Visit_____________________________________________
2. Date of Last Dental Visit _____________Does Dental Treatment Make You Nervous? Yes _________No_____________

3. Have You Ever Had Serious Trouble Associated With Previous Treatment? Yes _______________No________________

Explain_____________________________________________________________________________________

3. What Do You Use On A Daily Basis To Clean Your Mouth? Brush __________Floss _______Other______________________
4. Do You Have Any Of The Following Problems..?

Bleeding-Sore Gums ____ ______ Loose Teeth _____ _____

Bad Breath _____ _______ Sensitivity to Cold _____ _____ ___________

Burning Lips/Tongue _____ _____ Sensitivity to Hot ______ ______ _____________

Frequent blisters _____ _______ Sensitivity to Sweet ______ ______ _____________

Cheek Biting ______ _______ Sensitivity to Biting ______ _______ _____________

Difficulty Opening or Closing ______ _______ Food I impaction ______ ______ _____________

Clicking/Popping Jaw ______ ________ Pain in Jaw/Ears ______ _______ ______________

Frequent Headaches ______ ________

Have You Ever Been Treated For: Orthodontics (Braces) Yes______ No _______

Periodontal Disease Yes______ No _______

TMJ Yes ______ No _______

Appearance:

1. Are You Happy With The Appearance Of Your Front Teeth? Yes__________ No__________ Explain:_____________________
2. Do You Desire Whiter Teeth? Yes __________No __________Do You Desire Colored Fillings? Yes _______No__________
3. Are You Missing Teeth Which You Want Replaced? Yes ______No_______ Where_____________________
4. Do You Actively Engage In Any Sports Activities? Yes _____No _______What _______________________
5. Do you agree that pictures of you can be used for educational purposes? Yes ___________ No _____________

To The Best Of My Knowledge, All Of The Preceding Answers Are True And Correct. If I Ever Have Any Change in My Health Or Medication, I Will Inform **Smile Centers** At My Next Appointment.

**Financial Policy**

## Smile Centers PC

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your understanding of our policy.
We will be happy to submit your insurance claims form as a courtesy to you. We will even wait for payment from your insurance company. However, we do expect payment of your deductible and co-payment with each visit.

You must realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) or "U.C.R". "U.C.R" is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as a dental provider, our relationship is with you, and not with your insurance company. While filling insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems 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.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Date__________________ Name ______________________________

## Smile Centers PC

# NOTICE OF PRIVACY PRACTICES

### THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

### PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

### OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practice we describe in this notice while it is in effect. This notice takes effect from April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our private practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and health care operations. For example:

**Treatment:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal privacy Rules for its payment activities.

**Health Care Operations**: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accredition, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**On Your Authorization**: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends**: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use of disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

**Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

**Disaster Relief**: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit**: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence.

## Smile Centers PC

## SECTION A: The Patient.

NAME:_______________________________________________________________________________
ADDRESS: ____________________________________________________________________________
TELEPHONE: __________________ ____________EMAIL: ___________________________________
PATIENT NUMBER: _____________________________________ SSN# ___________________________

**SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.**

I, _________________________________________, ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES FROM THE ABOVE NAMED PRACTICE.

SIGNATURE _______________________________ DATE: ___________________

IF A PERSONAL REPRESENTATIVE SIGNS THIS AUTHORIZATION ON BEHALF OF THE INDIVIDUAL, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME: _______________________________________
RELATIONSHIP TO INDIVIDUAL: _____________________________________________

**SECTION C: GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT**.

DESCRIBE YOUR GOOD FAITH EFFORT TO OBTAIN THE INDIVIDUAL'S SIGNATURE ON THIS FORM:
______________________________________________________________________________________________________

DESCRIBE THE REASON WHY THE INDIVIDUAL WOULD NOT SIGN THIS FORM:
_________________________________________________________________________________

**SIGNATURE:**

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT:

SIGNATURE: _________________________________ DATE: ______________________
PRINT NAME: ____________________________ TITLE: _________________________

(Include this acknowledgement of receipt in the individual's records)

# Acknowledgment of receipt of privacy practices notice