

Welcome To Smile Design

Acknowledgement of Receipt of Notice of Privacy Practices
I have received a copy of HIPAA Notice of Privacy Practices.

Please Print Name

Signature

Date

In Office Use Only

- Individual Refused to sign
- Communication barrier prevented obtaining the acknowledgement
- An emergency situation prevented obtaining the acknowledgement

Patient Information (Confidential)

Date _____

Referred By: _____

Patient Name _____

Last

First

Middle

Birth Date: _____ Social Security # _____ Gender (M/F): _____

Marital Status (check): Minor _____ Single _____ Married _____ Divorced _____ Other _____

Home Address _____

Street

City

State

Zip

Email Address _____

Your e-mail address is used solely by our office for appointment reminders, monthly promotions, follow ups, and newsletters. If at any time you wish to OPT out of any or all of these services please contact the office.

Phone #s Home _____ Cell _____ Other _____

Employer: Name _____ Phone _____ ext _____

Address _____

Street

City

State

Zip

Emergency Contact: Name _____ Phone _____

Spouse or Responsible Party Information

Name _____

Last

First

Middle

Birth Date: _____ Social Security # _____ Gender (M/F): _____

Home Address _____

Street

Email _____

City

State

Zip

Phone #s Home _____ Cell _____ Other _____

Employer: Name _____ Phone _____ ext _____

Address _____

Street

City

State

Zip

Patient Medical History

- | | | | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No | | Yes | No |
| 1. Are you under medical treatment now?..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain..._____ | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?
If yes, what medication(s) are you taking?_____ | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you need to pre-medicate?..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco?..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances?..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you allergic to or have you had any reactions to the following? | | | | | | | | |
| Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (eg. Novacaine) | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
8. Women Only:
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| a) Are you pregnant or think you may be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Are you taking oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> |

9. Do you have or have you had any of the following?
- | | | | | | | | | |
|-----------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No | | Yes | No |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Frequently tired | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Aids/HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement/Implant | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

- | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult | | |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding | | |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced clicking, pain, and/or difficulty | | | 14. Do you have (please check) <input type="checkbox"/> dentures, | | |
| in opening and/or closing in relation to your jaw? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> partials and/or <input type="checkbox"/> implants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you had oral hygiene instructions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have you had any periodontal treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 17. Date of last cleaning:_____ | | |

CONSENT:

1. I _____ hereby authorize the doctor and/or staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine. As stated in the "Payment Policy" form, payment is due and payable at the time services are rendered unless other arrangements have been made. (See form for additional information).
4. I understand that a \$50 fee will be assessed for any missed appointments. Should I need to cancel or change any appointments, I understand that I need to give the office 24 hours notice
5. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date _____

Release of Information Consent Form

I _____, have read and understood the HIPAA Notice of Privacy Practices that was provided to me by Smile Design Dentistry. However, In the event that I may need them to do so, I grant permission for Smile Design Dentistry and or staff to: **(Please Check one of the following):**

- 1- Discuss any aspect of my treatment and or needs with my:
 - Spouse _____ (initial)
 - Parent (if patient is over 18) _____ (initial)
 - Other _____ (initial)
(Name)

- 2- Have the above designated person, pick up any dental appliances, x-rays or dental records on my behalf. _____ (initial)

- 3- I do not wish to have my information discussed with anyone outside of the parameters of Health Insurance Portability and Accountability Act of 1996.

Patient – Signature

Date

Smile Design Dentistry
Cosmetic and Family Practice

Our Policy of Care and Payment

Ensuring that our patients receive high quality care is the goal of our practice! We strive to see every patient on time; however emergencies can delay the schedule occasionally. We thank you for your understanding.

Payment Options:

- Cash or Check
- Major credit cards MasterCard and Visa
- Chase/Care Credit/Citi Bank Health Card (interest free financing available)

Applying for Chase/Care Credit/Citi Bank Health card only takes a few minutes and there is NO fee to apply.

Insurance Agreement

This agreement is made between the undersigned patient below and Smile Design Dentistry. This form must be read and signed by the patient or the responsible party before the practice can accept payments directly from your insurance carrier.

- Patient/responsible party understands and agrees that he/she is responsible for all treatment fees on the patient's account regardless of insurance estimates.
- Patient/responsible party understands and agrees that if for any reason your insurance carrier fails to pay the estimated portion that you are responsible for all balances on the account.

We accept and file insurance as a courtesy to our patients and insurance estimates are not a guarantee of payment by your insurance carrier. All insurance policies are not the same and it is the patient/responsible party's responsibility to understand their policy.

Broken Appointments

Please call the office 48 hours (business days) in advance if you need to change or cancel your appointment with our office. We understand that there extenuating circumstances at times but this will allow us to better serve other patients needing to get an appointment and is greatly appreciated. A \$50.00 set up and sterilization or broken appointment fee may be assessed if more than one appointment is broken without notice.

Patient/Responsible Party Signature

Date