Welcome to Smile Design

Patient Information (Confidential)

Date:________________________ **How did you hear about our office?** ________________________

Patient Name:____
Last **First** **Middle**

Preferred Name: ____

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

Marital Status (check): **Minor**______ **Single** _______ **Married** ______ **Divorced** ______ **Other**______

Spouse/Responsible Party (Minors):____________________ **Birth Date:** ____________________

Home Address: ____
Street

____
City **State** **Zip**

Phone #s: Home____________________**Cell**____________________**Other**____________________

Email Address: ____________________ @ ____________________ .com

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.

Employer: Name____________________**Phone**____________________**Ext**____________________

Address____
Street **City** **State** **Zip**

Emergency Contact: ____________________ **Phone:** ____________________

Insurance Information

Subscriber Name: ____________________ **Birth Date:** ____________________
Last **First** **M. I.**

ID/SS#: ____________________ **Group #:** ____________________

Insurance Company Name: ____________________ **Phone #:** ____________________

Employer: ____________________ **Phone:** ____________________ **Ext**: ____________________

Address: ____
Street **City** **State** **Zip**

PATIENT PRINTED NAME____ **DATE** ________________________

Patient Medical History

		Yes	No
1.	Are you under medical treatment now? If yes, please explain: ____________________________	☐	☐
	Primary Care Physician Phone: ________________________		
	Specialty Care Physician Phone: ________________________		
2.	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
	If yes, please explain: ____		
3.	Are you taking any medication(s) including non-prescription medicine?	☐	☐
	If yes, what medication(s) are you taking?__________________________________		
4.	Do you need to pre-medicate with antibiotics?	☐	☐
5.	Do you use tobacco?	☐	☐
6.	Do you use controlled substances?	☐	☐
7.	Are you allergic to or have you had any reactions to the following?		

	Yes	No		Yes	No		Yes	No
Barbiturates	☐	☐	Local Anesthetics (e.g. Novocain)	☐	☐	Latex Rubber	☐	☐
Iodine	☐	☐	Penicillin or any other antibiotics	☐	☐	Sulfa Drugs	☐	☐
Sedatives	☐	☐	Any Metals (e.g. nickel, mercury, etc.)	☐	☐	Aspirin	☐	☐
Other (please list	☐	☐	____________________________					

8. **Women Only:**

a)	Are you pregnant or think you may be pregnant	☐	☐
b)	Are you nursing	☐	☐
c)	Are you taking oral contraceptives	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Stroke	☐	☐	Liver Disease	☐	☐
Heart Attack	☐	☐	Easily Winded	☐	☐	Hepatitis/Jaundice	☐	☐
Mitral Valve Prolapse	☐	☐	Heart Trouble	☐	☐	Leukemia	☐	☐
Heart Murmur	☐	☐	Frequently tired	☐	☐	Cancer	☐	☐
Low Blood Pressure	☐	☐	Angina	☐	☐	Radiation Therapy	☐	☐
Heart Disease	☐	☐	Chest Pains	☐	☐	Recent Weight Loss	☐	☐
Cardiac Pacemaker	☐	☐	Thyroid Problem	☐	☐	Fainting/Seizures	☐	☐
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	Epilepsy/Convulsions	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐
Anemia	☐	☐	Asthma	☐	☐	Respiratory Problems	☐	☐
Glaucoma	☐	☐	Emphysema	☐	☐	Hay Fever/Allergies	☐	☐
Swollen Ankles	☐	☐	Aids/HIV Infection	☐	☐	Sexually Transmitted Diseases	☐	☐
Other	☐	☐	Joint Replacement/Implant	☐	☐	Stomach Troubles/Ulcers	☐	☐

10. Do you have a Living Will? ☐ ☐ If no, who will you appoint as your proxy if you are unable to make your own medical decisions?

Name: ________________________ Contact #: __________________ Relationship: _______________

Patient Dental History

What is the reason for your visit today? ____

If there is anything you would like to change about your smile, what would it be? ____________________________

	Yes	No		Yes	No
Do you have frequent headaches?	☐	☐	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Do you clench or grind your teeth?	☐	☐	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐	Have you ever had any difficult extractions in the past?	☐	☐
Have you had orthodontic treatment?	☐	☐	Do you have any sores or lumps in or near your mouth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐	Have you ever had any head, neck, or jaw injuries?	☐	☐
Have you had oral hygiene instructions?	☐	☐	Do your gums bleed while brushing or flossing?	☐	☐
Have you ever had prolonged bleeding following extractions?				☐	☐
Have you ever experienced clicking, pain, or difficulty opening/closing in relation to your jaw?				☐	☐

Do you have (please check): Dentures ☐ Partials ☐ and/or Implants? ☐

Have you had any periodontal treatment: Gingivitis ☐ Root Scaling ☐ Perio Maintenance ☐ or Arestin(antibiotics)? ☐

Patient/Resp. Party Printed Name: ____________________________ Relation to Patient: __________________

Patient/Resp. Party Signature: ____________________________ Date: ________________________

FOR OFFICE USE: Reviewed by Dr. ____________________________Date____________

PATIENT PRINTED NAME____ **DATE** ______________________________

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 payment for all dental services provided in this office to me, or my dependent, is my responsibility, including all fees associated with any credit card disputes. 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 per 30 minutes for the duration of your appointment time reserved, will be assessed to your account for any missed appointments. Should I need to cancel or change any appointment, I understand that I need to give the office 48 business 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/Resp. Party Printed Name: ______________________________ Relation to Patient: ____________________________

Patient/Resp. Party Signature: __________________________________ Date: ____

Witness Signature: ____ Date: ____

FOR OFFICE USE: Reviewed by Dr. _____________________________Date________________

PATIENT GIVING CONSENT

Patient Name: ____ **DOB:** ________________________

Address: ____

Telephone: _____________________________ **Email:** ____

TO THE PATIENT-PLEASE READ CAREFULLY

You are entitled to a copy of this consent after you sign it.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read the Notice of Privacy Practices before you decide whether or not to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosure we may make of your protected health information and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will make the revised Notice of Privacy Practices available upon request. Please understand that revocation of this Consent will not affect any action taken in reliance of this Consent before we received your revocation.

You may request a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Compliance Officer @ Telephone: (813) 524-0669
Address: 601 S. Harbour Island Blvd., Suite 213, Tampa, FL 33602

Right to Revoke: You have the right to revoke this Consent at any time, by submitting written notice of your revocation to the address listed above. Please understand that revocation of this Consent will not affect any action taken in reliance on this Consent before we received your revocation.

SIGNATURE

I, ____ have had the opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ____ Date: ____________________

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

- o Individual refused to sign
- o Communication barriers prohibited obtaining acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please explain) ____

Signature: ____ Date: ____________________

PATIENT/RELATIVE HIPAA CONSENT

I, ____, understand by signing this Consent form, I am giving my permission to Smile Design Dentistry to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: ____

Relationship to Patient: ____

RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Smile Design Dentistry restrict the disclosure of my PHI to those specified below:

Name: ____

Name: ____

Signature: ____ Date: _________________________

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

REVOCATION OF CONSENT

I revoke my Consent to use my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect any action taken in reliance of my Consent before you received this written Notice of Revocation.
I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date: _________________________

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

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
- Debits Cards (with Visa/MasterCard logo)
- Major Credit Cards (MasterCard, Visa, Amex, Discover)
- HSA/Flex Spending Debit Cards (with Visa/MasterCard logo)
- Care Credit (interest free financing available)
- Citi Bank Health Card
- Lending Club

Applying for Care Credit and similar Payment Plans only takes a few minutes, and there is NO fee to apply.

Broken Appointments

Please call the office 48 hours in advance if you need to change or cancel your appointment with our office. We understand that there are 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 the appointment is broken without notice.

Insurance Agreement/Account Balances

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, you are responsible for all balances on the account.
- Balances over 90 days are subject to be placed in collection's which will include a 33% admin fee.
- All custom ordered parts/materials are non-refundable. A refund request may not result in a full refund. Any related expenses will be deducted from Patient's refund. Patient must cancel any custom order within 24 hours, in writing, to prevent cases from being submitted to lab and to prevent any further related expenses.
- All patient refund requests and payment disputes are subject to a $35 admin fee for processing.

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.

Patient/Resp. Party Printed Name: ____________________ Relation to Patient: ____________________

Patient/Resp. Party Signature: ____________________ Date: ____________________

Witness Signature: ____________________ Date: ____________________

Patient Consent for Use of Credit Cards, Debit Card, and Financing
Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Smile Design Dentistry to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist with payment.

_______ I will not challenge such credit, debit, or financing card payments, once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.

_______ I agree that this non credit card challenge agreement is irrevocable.

_______ I understand that any Credit Card and CareCredit payments disputed by the patient/responsible party are subject to a $35 processing fee (per dispute), and will be charged to the patient.

Patient/Resp. Party Printed Name: ______________________ Relation to Patient: ____________________________

Patient/Resp. Party Signature: __________________________ Date: ____

Witness Signature: ____________________________________ Date: ____