Smith Family & Cosmetic Dentistry

Patient Information

Patient Name: ______________________________________ Date: __________

Last, First MI (Preferred Name)

Gender: __________ Family Status: __________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): __________ (Work): ______________ (Cell): ____________

Address: ____

Street Apartment #

____

City State Zip Code

Health Information

Date of Last Dental Visit: ________________ Date of Last X-Rays: ________________

Reason for this visit: ____

Have you ever had any of the following? Please check those that apply:

- ☐ ADD/ADHD
- ☐ Allergies *(hay fever/ seasonal)*
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer: __________
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Pacemaker/Defibrillator
- ☐ Psychiatric Disorder
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Pregnant
  Due date: __________
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy

OTHER:

☐ ______________
____
____

Are you currently taking any medications and/or supplements? Please list: ______________________

____

- Have you taken **any** medications in the last 12 months (including ones not required for medical reason)? ☐ Yes ☐ No
  If yes, please list and explain: ______________________________

____

- Have you ever had any surgeries? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________

  Name of Physician: ______________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ ______________

Signature of patient, parent or guardian Date

Referral Information

Who may we thank for referring you to our practice?

☐ Another patient ☐ Dental Office ☐ Bill Board ☐ Mailer ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice: ______________________

Smith Family & Cosmetic Dentistry

Insurance Information

None

☐ By checking this box, I am confirming that I currently **do not** have any form of dental insurance.

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID#: ______________ Group#: ______________

Insured Social Security #: ______________ *Sponsor's Rank *(Active Duty Military Only)* ______________

Insured's Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

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Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID#: ______________ Group#: ______________

Insured's Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

____

Information of Parent, Guardian, or Authorized Representative

Please fill out this box if patient is under 18 years of age

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________ Birth Date: ______________

Phone (Home): ______________ (Work): ______________ (Cell): ______________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Non-Parent/Guardian & Unaccompanied Minor

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have written authorization allowing this person to accompany your child(ren). The person brining your child will need to be over the age of eighteen and present a photo identification at time of service. This authorization gives the person permission to bring your child(ren) in, speak to the doctor, and give authorization for dental treatment.

I give the person(s) listed below permission to bring my child(rem) to Smith Family & Cosmetic Dentistry and to discuss dental information about my child(ren). I further authorize them to see all necessary dental records and make health care decisions of a routine nature as determined at the sole discretion of the Smith Family & Cosmetic Dentistry provider.
I also give them authority to make more serious or urgent medical/health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Individual accompanying child(ren): ______________ **Relationship to child(ren):** ______________

Child's Name: ______________ **DOB:** ______________

Child's Name: ______________ **DOB:** ______________

Child's Name: ______________ **DOB:** ______________

☐ By checking this box, I authorize my child(ren) to come to any/all dental appointments **unaccompanied** by a parent or legal guardian. In the event of a medical/health emergency, Smith Family & Cosmetic Dentistry has my permission to make any decisions regarding medical/health care if I cannot be reached in sufficient time to grant consent.

______________________________ ______________
Signature of Patient, Parent, or Guardian Date

Smith Family & Cosmetic Dentistry

Financial & Cancellation Policy

Dental Insurance: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your treatment costs. Therefore, you will be expected to pay your deductible and your estimated co-payment on the day the services are rendered. However, we cannot guarantee any estimated charges. We will gladly file your insurance claim. If for any reason your insurance company has not paid their estimated portion within 60 days from the day of treatment, you are responsible for payment in full at that time. It is your responsibility to notify us of any changes in your insurance coverage.

Financial policy: Financial arrangements for treatment rendered by Smith Family & Cosmetic Dentistry must be made in advance. This office depends upon reimbursement from the patient, parent, or guardian for the costs incurred during the course of their treatment(s). Our staff will work with you to determine the best possible payment option for you. However, I understand that the fee estimate given to me for said treatment is only valid for a period of six months (from the date of the patient examination and/or the date printed on your treatment plan). In addition, a service charge of 1 ½ % per month (18% per annum) will be charged to any unpaid account exceeding 60 days of continuous nonpayment (unless previous written financial arrangements are agreed upon). For all emergency dental services and/or after hours dental services must be paid for in cash at the time services are performed.

NSF check policy & collections: Payments made by check that are not honored by the bank will incur a returned check fee of $20 in addition to the amount the check was written for. A call will be given to the patient notifying them of the returned check and the amounts to be paid in full. The payment must be paid in the form of cashier's check, cash, or credit card. If you have a balance on your account that is past 90 days the account holder will be referred to a collection agency for payment.

Missed/Broken appointments: We respectfully ask that you give us a minimum of 48 hours' notice to cancel or reschedule your appointment. A broken appointment is defined as one in which the patient failed to show on time or cancelled their appointment with less than 24 hours' notice. Any missed or broken appointments will be subject to a rescheduling date which may be as great as 90 days from the day your appointment was missed or broken. If more than one appointment is broken, Smith Dental reserves the right to dismiss the patient.

I hereby agree to pay the estimated portion Smith Family & Cosmetic Dentistry has quoted me at the time treatment is rendered. I further agree that the services are of reasonable value, and that I will pay the estimated portion quoted, unless I object in writing at the time payment is agreed upon. If you fail to pay any amounts owed, or otherwise breach any terms of this agreement, you hereby agree to pay all costs incurred by Smith Family & Cosmetic Dentistry during attempted recovery of said payment, along with all reasonable attorney fees if suit be instituted.

☐ **By checking this, I understand the above information and agree with its contents.**

__________________________________ ________________________
Signature of Patient, Parent, or Guardian Date

HIPAA Authorization Form

Patient Name: ____ **Date of Birth:** ___________________
Smith Family & Cosmetic Dentistry is authorized to release protected health information about the above-named patient to the entities listed below.

Name: ____ Date of Birth: _____________________

Relationship to Patient: ______________________________

Name: ____ Date of Birth: _____________________

Relationship to Patient: ______________________________

☐ **I DO NOT wish to have any of my information released to any person other than myself.**
(Please sign below to acknowledge that no information will be disclosed to anyone without your permission, unless Smith Family & Cosmetic Dentistry is required by a law official with appropriate federal or state documents).

Description of Information to be Released: *(Please check all that apply)*

☐ Appointment Information ☐ Billing Information ☐ Prescription Information ☐ X-Rays

☐ Results of Labs/Tests ☐ Medical Information ☐ Pictures/Images

I understand that I have the right to revoke this authorization at any time, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to Smith Family & Cosmetic Dentistry. I understand that revocation is not effective in cases where information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

☐ **By checking this, I understand the above information and agree with its contents.**

______________________________________ _______________________
Signature of Patient, Parent, or Guardian Date

Smith Family & Cosmetic Dentistry

Communications Consent Form

You may give permission to Smith Family & Cosmetic Dentistry to communicate with you by email and/or text message (SMS). This form provides information about the risks of these forms of communication, guidelines for communication, and how we use these forms of communication. It will also record your consent or refusal for these forms of communication.

How We Will Use Email & Text Messaging: Smith Family & Cosmetic Dentistry uses these methods of communication only about non-sensitive and non-urgent issues. All communications to or from you may be part of your dental record. Please refer to our Notice of Privacy Policy for information permitting uses regarding privacy matters. We will not send any records through unsecure email. Smith Family & Cosmetic Dentistry primarily uses email and text to confirm upcoming appointments.

Risks of Using Email & Text Messages: *Risks include, but not limited to, the following:*

- Emails & texts can be circulated, forwarded, stored electronically and on paper and broadcast to unintended recipients.
- Senders can easily misaddress and send the information to unintended recipients.
- Backup copies may exist even after the sender and/or other recipient has deleted his/her copy.
- They can be intercepted, altered, forwarded or used without authorization or detection.
- They can be used as evidence in court.
- They may not be secure, and it is possible that a third party may breach the confidentiality of such communication.
- Data charges may apply.
- Smith Family & Cosmetic Dentistry is not liable for breaches of confidentiality caused by you or any third party.

** Smith Family & Cosmetic Dentistry primarily uses email and text to confirm upcoming appointments. Please provide us with a valid cell phone number and email address that you want these confirmations sent too.*

Name: ____ **Cell Phone**: _______________________________

E-mail Address: ____

☐ **Yes,** please sign me up to receive e-mail AND text messages.

☐ **NO,** I do not wish to be contacted via text messaging OR email.