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Patient Information

(Confidential)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

If Student, Name of School/College _____ City _____ State/Prov. _____ Zip/P.C. _____

How You Found Us? ☐ Google Search ☐ Email from us ☐ Post Card ☐ Our Sign ☐ Insurance ☐ Yelp ☐ Septa Ad

☐ Patient Referral (Name: _____) ☐ One of our Staff ☐ Other _____

Person to Contact in Case of Emergency _____ Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group# _____ Policy ID/# _____

Do You Have Additional Dental Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group# _____ Policy ID/# _____

Do You Have Medical Insurance? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group# _____ Policy ID/# _____

Pharmacy Name _____ Pharmacy Phone _____

Payment In Full at Each Appointment. ☐ Cash ☐ Personal Check ☐ Credit Card ☐ Debit Card

Responsible Party

Person Financially Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Authorization and Release

Payment is due in full at time of treatment unless prior arrangements have been approved. This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that i may need during diagnosis and treatment, with my informed consent.

X _____ _____ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date | Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

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Dental History

Patient Name _____

Reason for Today's Visit _____ Date of Last Dental Care ____/____/____

Former Dentist _____ Date of Last Dental X-rays____/____/____

Are you happy with your smile? ☐ Yes ☐ No Did you have Orthodontic treatment? ☐ Yes ☐ No

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Difficulty chewing
- ☐ Difficult extractions
- ☐ Food collection between the teeth
- ☐ Grinding or clenching teeth
- ☐ Ill-fitting dentures
- ☐ Loose teeth or broken fillings
- ☐ Missing teeth
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Are you taking or scheduled to begin taking Bisphosphonates for the treatment of osteoporosis, Paget's disease or complications from cancer? (e.g. Actonel, Aredia, Boniva, Fosamax, Zometa) ☐ Yes ☐ No

Have you any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates _____

Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken Fen-phen/Redux? ☐ Yes ☐ No

(Women)

Are you pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had problems with any of the following:

- ☐ Anemia
- ☐ Angina or Chest Pain
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Auto Immune Disease
- ☐ Back Problems
- ☐ Bleeding Abnormality
- ☐ Blood Disease
- ☐ Cancer
- ☐ Controlled Substance Use
- ☐ Chemotherapy
- ☐ Chronic Pain
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough Persistent or Bloody
- ☐ Diabetes (Type I or II)
- ☐ Eating Disorder
- ☐ Epilepsy or Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Heart Transplant
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice, Liver Disease
- ☐ High Blood Pressure
- ☐ HIV.AIDS
- ☐ Infective Endocarditis
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Low Blood Sugar
- ☐ Mental Health Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease (e.g. COPD)
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Diseases
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Sleep Disorders, Snoring
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Systematic Lupus Erythematosus
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcer or Gastrointestinal Disease
- ☐ Other_____
- ☐ Other_____

List medications you are currently taking and the correlating Diagnosis:

Allergies: (e.g. Latex, Drugs, Local Anesthesia, Antibiotics, other)

X_____ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date | Relationship to Patient

OFFICE USE ONLY:

_____ _____ ____/____/____

Doctor's Name (Print) | Doctor's Signature | Date

REV 7.22.2016

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PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name: _____ DOB: _____/_____/_____

By signing this paper below, I give permission to the person(s) to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information that is shared with my family/friend is in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission: _____/_____/_____

Name of Individual: _____ Relationship to Patient: _____

Comments/Instructions: _____
(i.e. pick up prescription, reminder of routine treatment)

Patient/Guardian Initials: _____

THE DENTIST/STAFF HAS MY PERMISSION TO: (Please check all that apply)

___ Leave message at home with my spouse or: NAME: _____

RELATIONSHIP: _____ DOB: _____/_____/_____

___ Leave message on cell phone.

Cell phone number: _____

___ Leave message at work.

Work phone number: _____

___ Leave a message on voicemail.

Phone number: _____

___ Leave a detailed message on answering machine:

Phone number: _____

___ In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password: _____

_____

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship (if not self)

REV 7.22.2016

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE, EFFECTIVE SEPTEMBER 23, 2013, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFROMATION. PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your health information to another dentist or healthcare provider within our practice that may be providing treatment to you or if we refer you to another health care provider outside of our practice.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information (i.e. specific treatment procedures) with your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use or sell your health information for marketing communications without your specific written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us, however any message will be limited to only the necessary information required to contact you or confirm your appointment.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. **You have the option of opting out of these communications.**

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written 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 already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated.

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which our business associates or we disclosed your health information for purposes other than treatment, payment, and healthcare operations.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended..

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

Patient's right to restrict information:
A patient may request that certain disclosures of Protected Health information to a health plan where the patient pays out of pocket in full for the particular service.

Breach Notification:
Simply Beautiful Smiles takes patient privacy extremely seriously. If, despite our best efforts, a patient's private information is breached in any way, we will notify the patient whose information has been breached immediately following discovery of said breach.

Acknowledgment of Privacy Notice:

_____	_____	_____
Name (print)	Signature	Date
_____	_____	_____
Witness (print)	Signature	Date

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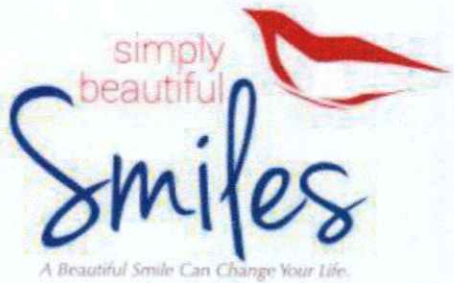
Acceptance of Uncovered Charges

I _____ hereby acknowledge that it is probable that my insurance plan will not pay for all charges incurred in this office. I acknowledge that I am responsible for any charges refused or discounted by my insurance company. Further, I will pay for any collections or legal charges incurred in the collection of these charges, should I fail to pay them during the agreed upon time.

Signed _____ Date_____

Witness _____ Date _____



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Request and Permission for Dental Treatment

Patient Name: _____
Please Print

Legal Guardian (If patient is under 18 years of age) _____
Please Print

I hereby authorize the dentist and staff to treat me or the person under my care (I am the legal guardian).

I understand that during the course of treatment, complications may arise, which could necessitate additional or alternative procedures. Such complications can include, but are not limited to, the need for root canal or extraction.

I understand that there may be multiple options to treatment, all with associated risks and benefits. I further understand there may be consequences associated with refusing treatment.

I consent to the use of local anesthetics ("Novocain"), antibiotics and analgesics (pain medication), and understand there may be potential risks associated with their use or the use of any drug. These risks include allergic reaction, aspiration pain, cardiac arrest, discoloration and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs. Injury to nerves during local anesthetic injection is rare, but may lead to "numbness" that lingers beyond the usual period of time.

I consent to the use of nitrous oxide analgesia, if I do desire. I understand that there are risks and benefits of its use.

I confirm that I have read and fully understand all of the information provided above.

Patient/Legal Guardian Signature: _____

Date: _____