Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely with ink. If you have any questions or need assistance, please ask us – we are happy to help.

SS#/SIN _____
Date _____

Patient Information (Confidential)

Name _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Email _____ Home/Cell _____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Other

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____City _____ State _____ Zip_____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone_____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone_____

Email _____ Cell Phone _____

Driver's License # _____ Birth date _____ Financial Institution_____

Employer _____ Work # _____ SS#/SIN _____

Is this person currently a patient at our office? ☐Yes ☐No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐Cash ☐Personal Check Credit Card ☐Visa ☐MasterCard ☐American Express ☐Discover ☐Care Credit ☐Lending Club

☐I wish to discuss the office's payment policy

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS#/SIN_____ Date Employed _____

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

Address of Employer _____ City _____ State _____ Zip_____

Insurance Company _____ Group#_____ Policy/ID#_____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐Yes ☐No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS#/SIN_____ Date Employed _____

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

Address of Employer _____ City _____ State _____ Zip_____

Insurance Company _____ Group#_____ Policy/ID#_____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

(Over please)

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? ☐Yes ☐No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐Yes ☐No
   If yes, please explain _____
   _____
3. Are you taking any medication(s) including non-prescription medicine? ☐Yes ☐No

If yes, what medication(s) are you taking? _____
_____

4. Have you ever taken Fen-Phen/Redux? ☐Yes ☐No
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ☐Yes ☐No
6. Have you ever taken Viagra, Revati, Cialis, or Levitra in the past 24 hours? ☐Yes ☐No
7. Do you use tobacco? ☐Yes ☐No
8. Do you use controlled substances? ☐Yes ☐No
9. Do you have or have you had any of the following?

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

10. Are you wearing contact lenses? ☐Yes ☐No
11. Are you allergic to or have you had any reactions to the following:

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

Other (please list)_____

12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks?) ☐Yes ☐No
13. Women Only:
    a. Are you pregnant or think you may be pregnant ☐Yes ☐No
    b. Are you nursing? ☐Yes ☐No
    c. Are you taking oral contraceptives? ☐Yes ☐No

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? ☐Yes ☐No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐Yes ☐No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐Yes ☐No
4. Do you feel pain to any of your teeth? ☐Yes ☐No
5. Do you have any sores or lumps in or near to your mouth? ☐Yes ☐No
6. Have you had any head, neck or jaw injuries? ☐Yes ☐No
7. Have you ever experienced any of the following problems in your jaw?
   Clicking ☐Yes ☐No
   Pain (joint, ear, side of face) ☐Yes ☐No
   Difficulty in opening or closing ☐Yes ☐No
   Difficulty in chewing ☐Yes ☐No
8. Do you have frequent headaches? ☐Yes ☐No
9. Do you clench or grind your teeth? ☐Yes ☐No
10. Do you bite your lips or cheeks frequently? ☐Yes ☐No
11. Have you ever had any difficult extractions in the past? ☐Yes ☐No
12. Have you ever had any prolonged bleeding following extractions? ☐Yes ☐No
13. Have you had any orthodontic treatment? ☐Yes ☐No
14. Do you wear dentures or partials? ☐Yes ☐No
    If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐Yes ☐No
16. Do you like your smile? ☐Yes ☐No
17. Do You Snore? ☐Yes ☐No
18. Have you been diagnosed or treated for sleep apnea? ☐Yes ☐No

Authorization and Release I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. **I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.** I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependants.

x_____
Signature of patient (or parent/guardian of minor) Date

SMILE STUDIO

Spring Lake

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. Our primary relationship is with you, our patient. We are independent of all insurance contracts. Our goal is to deliver the finest dentistry possible and to help you maximize your insurance benefits. As a courtesy to you, our office provides certain services, including filing claims for your dental benefits. At your request, we can send pre-treatment estimates to your insurance company. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.

If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered.

FULL PAYMENT is due at the time of service. If insurance benefits apply, they will be assigned to reimburse you directly, unless other arrangements are made prior to treatment.

UNPAID BALANCE: In the event that a balance is left unpaid and payment is delinquent a 2.5% monthly finance charge may be incurred and the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

RETURNED CHECK: There will be a $35.00 fee for any returned checks.

MISSED APPOINTMENTS: Unless we receive notice of cancellation 48 hours in advance, by phone, you may be charged $75. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient Signature: Date:

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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 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 changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our 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.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use 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 must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare; but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

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

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this website. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

SMILE STUDIO

Spring Lake

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Today's Date: _____

Patient's Name (print): _____

Patient's Date of Birth: _____

I acknowledge that I have received a copy of Smile Studio of Spring Lake HIPAA notice of privacy practices.

Signature of Patient/Guardian: _____

SMILE STUDIO

Spring Lake

Model Release Form

I, _____ hereby give consent to Smile Studio of Spring Lake to use my dental photograph(s), testimonial, video, slides, models or any other image(s) with or without my name for educational purposes and in the use of promoting cosemtic dentistry.

Signature: _____

Date: _____