smileworks
REVEALING THE NATURAL BEAUTY OF SMILES

Patient Information

Patient Name: _____ Date: _____

Last First MI

E-mail: _____ Phone #: _____ ☐ I would like to receive correspondences via email

Whom may we thank for referring you to our practice: _____

If not referred by a patient, please let us know how you heard about us. _____

Emergency Contact Information

Name: _____ Phone #: _____ Relationship to patient: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. We believe in the importance of quality dental care, and we strive to provide the best dental treatment possible. We also understand the financial limitations that influence your choice of care. We want to assure you of our flexible approach to financing. The practice depends upon reimbursement from the patients costs incurred in their care and financial responsibility on the part of each patient. We will file to most insurance policies as a courtesy, and receive reimbursements from the dental insurance companies with your permission. We always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. Patients who carry dental insurance understand that all dental services furnished are charged on the day the services are rendered. At the time of service, we will ask you for an estimated co-payment and any deductibles that may apply. Insurance plans generally only cover a portion of total treatment costs. It is your responsibility to pay any balance not paid by the insurance company since insurance coverage is between you and your insurance company. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. If your account becomes past due, we will take necessary steps to collect the balance owed. If we have to refer your account to a collection agency, or small claims court, you agree to pay all of the cost/ fees which are incurred. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matter related to this form.

BROKEN APPOINTMENTS – Patient visits are the most integral part of our day. We reserve time and prepare in advance for each patient's arrival. Please understand that when we make an appointment, we are setting aside enough time to do our best work and each appointment is for one patient only. Therefore, a broken appointment without adequate notice results in wasted time for us, adding to the cost of providing care to our patients. We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those the best we can. If you are unable to keep your scheduled appointment, we kindly ask you give us 24 hour notice. We will assess a fee of $50 for last minute cancellations, missed appointments and short notice rescheduling. We will consider exceptions on an individual basis. I have read the above conditions of treatment and payment and agree to their content.

_____

Signature of patient, parent or guardian Date Relationship to patient

Privacy Practices Acknowledgement – HIPAA

I understand that Smileworks strictly adheres to the ***Health Insurance Portability & Accountability Act of 1996*** ("HIPPA") including the OMNIBUS Ruling in order to protect my privacy as a patient. As a patient, I understand that my information can be used to conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly. It may also be used to obtain payment from the third party payers or conduct normal healthcare operations such as quality assessments and physician certifications. I understand that if I would like to read a detailed Notice of Privacy Practices, I may request to see one at anytime and one will be furnished.

_____

Signature of patient, parent or guardian Date Relationship to patient

Pediatric Medical History 14 _UNDER Updated(Copy)

Patient Name: Birth Date: Date Created:

Health History

Is your child in good health?	Yes No
Does your child have regular medical exams?	Yes No
Are your child's immunizations current?	Yes No
Is your child presently taking medication?	Yes No
Any history of allergic reaction to medication?	Yes No
Has your child been hospitalized since birth?	Yes No

Please check any that pertain to your child

Asthma	Allergies	Bleeding Disorder	Brain Injury
Cerebral Palsy	Diabetes	Emotional disorder	Epilepsy
Hearing Disorder	Hepatitis	Kidney Disease	Liver disease/ jaundice
Lung Problem	Mental disability	Mental disorder	Nervous disorder
Sickle cell anemia/ Trait	Speech disorder	Tuberculosis	Vision disorder
ADHD	Autism		

Allergies

Are you allergic to any of the following?

Aspirin	Yes No	Penicillin	Yes No	Codeine	Yes No	Acrylic	Yes No
Metal	Yes No	Latex	Yes No	Sulfa Drugs	Yes No	Local Anethetics	Yes No

Dental History

Is this your child's first dental visit?	Yes No
Any unfavorable experiences in a dental office?	Yes No
Does your child have a toothache?	Yes No

What is your water source?

Private System	Yes No
Public System	Yes No

Does your child snore?	Yes No
Is your child a finger sucker?	Yes No
Does your child use a pacifier?	Yes No
Was your child bottle fed?	Yes No
Was your child breast fed?	Yes No

I agree to diagnostic procedures and dental treatmetns as found necessary and desireable by Smileworks for the patient named above. I am aware that I will be informed of all services before any

Signature of Patient, Parent or Guardian:

X Date:_____

Dental History

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Patient Name: _____ Date: _____

What is the reason for your visit today _____

_____

Are any of your teeth sensitive to *hot or cold*? YES NO
Are any of your teeth sensitive to *sweets*? YES NO
Any sensitivity to *biting or chewing pressure*? YES NO
Do you notice mouth odors? YES NO
Do you notice bad tastes? YES NO
Do your gums bleed or hurt? YES NO
If yes, how often? _____
Does food get caught between your teeth? YES NO
Is this a problem you want corrected? YES NO
Do you clench or grind your teeth? YES NO
Do you ever notice tired jaws or sore teeth? YES NO
Do you smoke or chew tobacco? YES NO
Are you currently missing any teeth? YES NO
Is this a problem you want corrected? YES NO

Have you ever had braces? YES NO
Have you ever had oral surgery? YES NO
Have you ever had periodontal surgery? YES NO
Do you wear a bite or "night" guard? YES NO
Any serious injury to the mouth or head? YES NO
Please describe: _____
_____
Does your jaw click or pop? YES NO
Any pain in your jaw joint? YES NO
Frequent headaches? YES NO
Frequency and time of day of headaches: _____
_____
Do you feel nervous about dental treatment? YES NO
If so, what are your concerns? _____

Date of: Last dental visit? _____ Last cleaning? _____ Last x-rays? _____

What was done at your last dental visit? _____
_____

Previous Dentist's Name: _____ Phone #: _____

Your reason for leaving their office: _____
What did you **like** about your previous dental experiences? _____
_____

What did you **dislike** about your previous dental experiences? _____
_____

How often do you normally have dental examinations? Once per year Twice per year Three times per year More

How often would you prefer dental examinations? Once per year Twice per year Three times per year More

Would you like to discuss your options to enhance your smile? (i.e. whiter, straighter teeth) YES NO

If yes, what are your goals & expectations? _____

Are you concerned about your silver mercury fillings? YES NO

Is there anything else / other dental concerns we have not asked about that you want us to know? _____
_____
_____

How can we make each of your future visits more enjoyable? _____
_____

NOTES: _____
_____

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SMILEWORKS HIPAA INFORMATION RELEASE TO DESIGNATED REPRESENTATIVE

At my request, I authorize Smileworks General and Cosmetic Dentistry to disclose my protected health information to:

****if name is not listed, we CANNOT disclose any of your information to anyone other than yourself****

1. Family Member/Personal Representative: _____

   Relationship to Patient: _____ Phone Number: _____

2. Family Member/Personal Representative: _____

   Relationship to Patient: _____ Phone Number: _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I: Acknowledgement of Practice's Notice of Privacy Practices:

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____	_____	_____	
Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date