INNOVATIVE SMILES AT THE FORUM

PATIENT INFORMATION

PATIENT INFORMATION

PATIENT FIRST NAME:	MI:	PATIENT LAST NAME:	PATIENT SOCIAL SECURITY NO:	TODAY'S DATE:
			___-___-____	MM/DD/YY

ADDRESS	CITY:	STATE/ZIP CODE:	DRIVERS LICENSE NO:

HOME PHONE:	WORK PHONE:	CELLULAR PHONE:	E-MAIL:
			☐ I would like to receive correspondence via e-mail

DATE OF BIRTH	AGE:	GENDER	MARITAL STATUS:
MM/DD/YY		☐ MALE ☐ FEMALE	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

EMPLOYMENT/STUDENT STATUS:	PERSON FINANCIALLY RESPONSIBLE FOR SERVICES:
STUDENT: ☐ Full Time ☐ Part Time EMPLOYMENT: ☐ Full Time ☐ Part Time ☐ Retired	☐ Patient is the responsible party for payment for dental services ☐ Patient is a policy-holder of responsible party

CONTACT IN CASE OF EMERGENCY

NAME:	HOME PHONE:	WORK OR CELL PHONE:	RELATIONSHIP:

RESPONSIBLE PARTY

(Please complete only if responsible party is someone other than the Patient)

FIRST NAME:	MI:	LAST NAME:	SOCIAL SECURITY NO:	DATE OF BIRTH

ADDRESS:	CITY:	STATE/ZIP CODE:	DRIVER'S LICENSE NO:

HOME PHONE:	WORK PHONE:	CELLULAR PHONE:	RELATIONSHIP TO PATIENT:

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURED:	RELATIONSHIP TO PATIENT:

SOCIAL SECURITY NO:	DATE OF BIRTH:
___-___-____	MM/DD/YY

EMPLOYER:	INSURANCE COMPANY:

ADDRESS:	

CITY:	STATE/ZIP:

EMPLOYER PHONE:	EMPLOYER ID:	GROUP #:

SECONDARY INSURANCE

NAME OF INSURED:	RELATIONSHIP TO PATIENT:

SOCIAL SECURITY NO:	DATE OF BIRTH:
___-___-____	MM/DD/YY

EMPLOYER:	INSURANCE COMPANY:

ADDRESS:	

CITY:	STATE/ZIP:

EMPLOYER PHONE:	EMPLOYER ID:	GROUP #:

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PATIENT MEDICAL HISTORY

PATIENT NAME:_____ DATE: _____

PLACE A MARK ON "YES" OR "NO" TO INDICATE ANY OF THE FOLLOWING:

Are you under the care of a physician?
☐*No* ☐*Yes* If yes, please explain: _____

Do you have any general health problems?
☐*No* ☐*Yes* If yes, please list: _____

Are you currently taking any drugs or medications?
☐*No* ☐*Yes* If yes, please list: _____

Are you allergic to any medications?
☐No ☐Yes If yes, please list: _____

What is the name of your pharmacy? _____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

	NO	YES		NO	YES		NO	YES
AIDS	☐	☐	Fainting or dizziness	☐	☐	Psychiatric Care	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation Treatment	☐	☐
Arthritis, Rheumatism	☐	☐	Hay Fever	☐	☐	Respiratory Disease	☐	☐
Artificial Heart Valves	☐	☐	Headaches	☐	☐	Rheumatic Fever	☐	☐
Artificial Joints	☐	☐	Head Injuries	☐	☐	Scarlet Fever	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Shortness of Breath	☐	☐
Back Problems	☐	☐	Heart Problems	☐	☐	Sinus Problem	☐	☐
Bleeding Abnormally, after	☐	☐	Hepatitis - Type:( )	☐	☐	Skin Rash	☐	☐
extractions or surgery			Herpes	☐	☐	Special Diet	☐	☐
Blood Disease	☐	☐	High Blood Pressure	☐	☐	Stomach Problem	☐	☐
Cancer	☐	☐	HIV Positive	☐	☐	Stroke	☐	☐
Chemical Dependency	☐	☐	Jaundice	☐	☐	Swelling of Feet or Ankle	☐	☐
Chemotherapy	☐	☐	Jaw Pain	☐	☐	Swollen Neck Glands	☐	☐
Circulatory Problems	☐	☐	Kidney Disease	☐	☐	Thyroid Problems	☐	☐
Congenital Heart Lesion	☐	☐	Liver Disease	☐	☐	Tonsillitis	☐	☐
Cortisone Treatments	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Cough, persistent or bloody	☐	☐	Mitral Valve Prolapse	☐	☐	Tumor or Growth on Head	☐	☐
Diabetes	☐	☐	Nervous Problems	☐	☐	or Neck		
Emphysema	☐	☐	Pacemaker	☐	☐	Ulcer	☐	☐
Epilepsy	☐	☐				Venereal Disease	☐	☐
			Women: Are you pregnant?	☐	☐			
Do you wear contact lenses?	☐	☐	Date Due? _____.			Unexplained Weight loss?	☐	☐
			Are you nursing?	☐	☐			

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____

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PATIENT DENTAL HISTORY

Dental History Form ----- Patient Name_____

1. Are your teeth sensitive to hot or cold?_____
2. Are your teeth sensitive to sweets?_____
3. Do you floss daily?_____if not, how often do you floss?_____
4. Do you experience bleeding gums or pain in the gum area?_____
5. Have you ever been told you have gum disease?_____
6. Is there any history of periodontal (gum) disease in your family?_____
7. Have you ever had braces?_____
8. Do you notice any loose teeth or change in your bite?_____
9. Do you have any crowding or spaces you would like to correct?_____
10. Are you interested in hearing what your options are for saving your natural teeth?

    _____

11. Do you have any outstanding treatment from your previous dentist?

    _____

12. Why didn't you move forward with the recommended treatment?

    _____

13. Why did you leave your last dentist?

    _____

14. How important is dentistry to you?

    _____

15. What are your dental goals?

    _____

INNOVATIVE SMILES AT THE FORUM

INNOVATIVE SMILES AT THE FORUM, P. C.
FINANCIAL AND CONFIRMATION STANDARDS

PATIENT NAME: _____

1. FINANCIAL OBLIGATIONS:

The financial obligation for dental treatment is between you and this office and is not dependent upon insurance coverage. Payment for dental services is due at the time when treatment and services are rendered. Our professional services are rendered to the patient, not the insurance company. Therefore, the patient is responsible for any applicable deductibles and co-payments at the time of treatment. Any insurance disallowance will be the patient's responsibility. If the insurance company has not paid within 45 days after the day of service, the patient will be required to pay the insurance portion and settle the claim directly with the insurance company.

2. PAYMENT OPTIONS:

Specific payment options will be discussed on an individual basis. Payment options may include cash installations based on your treatment plan, third party financing, and insurance coverage. We accept cash, personal checks, and most major credit cards including VISA, MASTERCARD and American Express.

3. INSURANCE FILING:

As a courtesy to our patients, we file insurance claims and wait for the insurance portion payments. The patient is responsible for providing proof of insurance before all appointments. If the insurance company has not paid within 45 days after the day of service, the patient will be required to pay the insurance portion and settle the claim directly with the insurer.

NOTE: (Any applicable insurance co-payments, deductibles, and any portion of the payment due for treatment and service not covered by your insurance company, are due at the time of services and treatment).

4. APPOINTMENT CANCELLATION POLICY:

We try very hard to adhere to the reserved time for our patient's appointments; therefore we appreciate it when our patients do the same. Since we reserve a place for you and other patient's on the day and time of your appointment, we ask you to please give us at least 48 hours advanced notice if you are unable to keep your appointment. Only in this manner are we able to provide the optimum treatment our patients demand and deserve.

NOTE: (Courtesy reminders are sent out via e-mail and/or phone calls one week prior and 2 days to your appointment. If requested, all reserved appointments are considered confirmed at the time your appointment is made (either by phone or in person).

We understand there are emergencies. However, we reserve the right to bill your account $75 or if you have a credit on your account we have the right to apply it to your cancellation fee if you fail to give 48 hours notice that you will be unable to keep your appointment. No charge for your need to reschedule provided you give us 48 hours notice. Broken appointments affect many patients.

Our team has made a promise, professionally and personally, to give you the concern, respect and care that makes our office a comfortable and pleasant place to visit. We ask that you give us enough warning so that we can treat another patient.

5. DELINQUENT ACCOUNTS:

If your account becomes delinquent and is turned over to a collection agency, additional finance charges may be applied to your account.

I am aware and accept my financial obligations and agree with the financial and cancellation policies above mentioned.

Signature:_____ **Date:** _____

INNOVATIVE SMILES AT THE FORUM

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As requires by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgement in disclosing only the health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization In writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below.

- The right to request restrictions on certain uses and disclosures of protected health information, including these related to disclosures to family members, other relatives, close personal friends, or any other person identified to you. We are, however not required to agree to a requested restriction. If we agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, **20**_____, and we are required to abide by terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our Notice of Privacy practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices please contact our office.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave. SW, Washington, DC

INNOVATIVE SMILES AT THE FORUM

ACKNOWLEDGEMENT OF PRIVACY PRACTICE

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate mt treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more compete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, buy if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ Date: _____

Signature: _____ Relationship to Patient:_____

Dependent family members also covered by this acknowledgment:

_____

_____

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason or reasons;

☐ The patient refused to sign

☐ Communication barriers

☐ Emergency situation

☐ Other

THANK YOU FOR YOUR VISIT!