AllSmiles DENTAL

Patient Information

Chart # _____

Patient Name_____ **Date of Birth**_____

Address_____ **Circle: Male / Female**

City _____ **State** _____ **Zip** _____ **County** _____

Telephone #_____ **Work #**_____

E-mail_____ **SSN**_____-_____-_____

Emergency Contact_____ **Phone** _____

Dental History

Reason for today's visit _____

Previous Dentist_____ Location_____ Phone _____

Last dental visit_____ Last teeth cleaning _____ Last x-rays taken _____

Are you happy with the appearance of your teeth? ☐ Yes ☐ No

Do your gums bleed often when brushing? ☐ Yes ☐ No

Have you noticed any loose teeth? ☐ Yes ☐ No

Have you ever had an unpleasant dental experience? ☐ Yes ☐ No

Do you require a **pre-med** prior to dental treatment? ☐ Yes ☐ No

Have you had: ☐ Orthodontic Treatment ☐ Oral Surgery ☐ Gum Treatment ☐ TMJ Treatment ☐ Mouth Appliance

Have you noticed: ☐ Jaw Clicking ☐ Pain ☐ Difficulty Opening or Closing ☐ Difficulty in Chewing

Dental Habit: ☐ Clenching teeth while awake or asleep ☐ Thumb, Finger(s) or Pacifier Sucking

Medical History

Name of Physician_____ **Phone**_____

Are you under a physician's care now? ☐ Yes ☐ No explain_____

Have you ever been hospitalized? ☐ Yes ☐ No explain_____

Have you had a back/head/neck injury? ☐ Yes ☐ No explain_____

Do you smoke or use tobacco? ☐ Yes ☐ No explain_____

Do you use controlled substances? ☐ Yes ☐ No explain_____

Are you taking Fosamax, Actonel, Boniva, Aredia or Zometa? ☐ Yes ☐ No explain_____

List current drugs, pills and medications that you are taking (or please attach medication list):

_____

Pharmacy Name_____ **Phone** _____

Women Are you: Pregnant? ☐ Yes, due date_____ ☐ No, Nursing? ☐ Yes ☐ No, Taking oral contraceptives? ☐ Yes ☐ No

Please check if you are **Allergic** to:

☐ Acrylic ☐Aspirin ☐ Codeine ☐ Latex
☐ Local Anesthetic ☐Metal ☐ Sulfa ☐ Penicillin
☐ Other Allergies_____

Check the box if you have or had any of the following:

Central Nervous System:

☐ Anaphylaxis
☐ Convulsions
☐ Epilepsy or Seizures
☐ MS or Parkinson's Disease
☐ Fainting/Dizzy Spells
☐ Frequent Headaches
☐ Shingles
☐ Spina Bifida
☐ Paralysis

Bone/Muscles:

☐ Arthritis or Gout
☐ Artificial Joint
☐ Cortisone Treatments
☐ Rheumatism

Hematologic System:

☐ Anemia
☐ Blood Disease
☐ Blood Thinner Use
☐ Blood Transfusion
☐ Bruise Easily
☐ Excessive Bleeding
☐ Hypoglycemia
☐ Hemophilia
☐ Leukemia
☐ Sickle Cell Disease

Kidney/Liver:

☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Liver Disease
☐ Kidney Problems
☐ Kidney Transplant
☐ Yellow Jaundice
☐ Renal Dialysis
☐ Genital Herpes
☐ Venereal Disease

Immune System:

☐ AIDS or HIV Positive
☐ Cancer
☐ Chemotherapy
☐ Radiation Treatment

Respiratory:

☐ Asthma
☐ Breathing Problems
☐ Inhaler Use
☐ Emphysema
☐ Frequent Cough
☐ Lung Disease
☐ Tuberculosis
☐ Hay Fever
☐ Sinus Problems

Cardiovascular:

☐ Angina
☐ Artificial Heart Valve
☐ Infective Endocarditis
☐ Chest Pains
☐ Congenital Heart Disorder
☐ Heart Attack/Failure
☐ Heart Disease
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Transplant
☐ Irregular Heart Beat
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Mitral Valve Prolapsed
☐ Rheumatic Fever
☐ Stroke
☐ Swelling of Limbs

Digestive System:

☐ Crohn's Disease
☐ Frequent Diarrhea
☐ Frequent Vomiting
☐ Heartburn
☐ Intestinal Disease
☐ Stomach Disorder
☐ Stomach Ulcers

Endocrine System:

☐ Diabetes
☐ Dry Mouth
☐ Excessive Thirst
☐ Parathyroid Disease
☐ Recent Weight Loss
☐ Thyroid Disease

Other:

☐ Rash or Hives
☐ Cold Sores/Herpes
☐ Mouth Lesions/Sores
☐ Tumors or Growths
☐ Tonsillitis
☐ Scarlet Fever
☐ Glaucoma or Blindness
☐ Hearing Impairment
☐ Enzyme Deficiency
☐ Alzheimer's Disease
☐ Anorexia or Bulimia
☐ Alcohol Dependency
☐ Drug Addiction
☐ Depression
☐ Psychiatric Care
☐ Other_____
_____
_____

I certify this medical information to be true and correct to the best of my knowledge. I understand providing incorrect information can be dangerous to my health and it is my responsibility to inform the dental office of any medical changes.

Signature_____**Date**_____
Patient, Parent or Guardian

Signature_____**Date**_____
Provider

Notification of Policies Received & Reviewed

Appointment Policy

All Smiles Dental requests a 24-hour notice on all appointment changes or cancelations. An appointment broken, cancelled, failed or rescheduled less than 24 hours is counted and I understand that I may be dismissed as a patient upon three of these occurrences. I have read and understand the Appointment Policy.

Privacy Policy

I, _____ have received a copy of All Smiles Dental's Privacy Practices in accordance with HIPAA.

Financial Policy

I understand that providing incorrect information can affect my insurance payment and it is my responsibility to inform the dental office of any changes that may occur.

I certify that my information is correct and true.

I have received a copy of All Smiles Dental's Financial Policy. I understand that co-pays, deductibles and non-covered services are payable the same day that service is provided.

Signature on File

I hereby request that payment of authorized benefits be made to All Smiles Dental for services provided to me. I understand that any portion unpaid or denied by my dental insurance company is my responsibility and will be paid by me according to the All Smiles Dental Financial Policy. I authorize the release of any information that the dental benefits provider may require to determine the benefits payable. I permit a copy of this authorization to be kept on file and used in place of the original.

Signature:_____ **Date:**_____

Appointment Policy

To Our Patients

At All Smiles Dental, your oral health is very important to us. We understand that your time is very valuable. We realize that occasionally unforeseen circumstances may necessitate the canceling or missing a scheduled appointment. Our clinic dedicates this time to give you the individual treatment that you deserve for optimal dental care. It is this very reason that we have found it necessary to implement our appointment policy.

Confirmation Calls

As a courtesy, All Smiles Dental will try to contact you by phone call, email or text, prior to your scheduled appointment to confirm the appointed date and time. Ultimately, it is your responsibility to know when your appointment is scheduled. You may call us to verify anytime.

What to do if you cannot make your appointment

If you are unable to make your appointment, please call All Smiles Dental to reschedule your appointment as soon as possible.

All Smiles Dental requires a 24-hour notice if you decide to cancel or reschedule your appointment. Your scheduled appointment is reserved for you and you only. If you cannot make it, please inform us ASAP so that we can give that time to another patient who is waiting to be seen. We value your time and would ask you to do the same for us and other patients.

Less Than 24-Hour Notice

All Smiles Dental does not charge additional fees (like other dental clinics) per broken, cancelled, failed or rescheduled appointment less than 24-hours. All Smiles Dental is committed to our patient's oral health and their time. However, upon **3 (three)** broken, failed, cancelled, or rescheduled appointments less than a 24-hour notice, will result in a patient **dismissal** from All Smiles Dental. If an emergency situation caused the patient to miss an appointment, bad weather or if a clinic error was made, the occurrence will not be considered a no-show/broken appointment.

Late Arrival

If you are more than 15 minutes late to your scheduled appointment, we will try our best to provide the treatment for you if schedule allows but we may have to ask you to reschedule.

Thank you in advance for your help in allowing us to provide dental services to you and others!

Privacy Policy

This notice discribes how medical information about you may be used and how you can get access to this information. Please review it carefully.

The Health Insurance Portablility & Accountablility Act of 1996 (HIPAA) is a federal program that all medical records and other individual identifiable health information used or disclosed by us in any form, whether electronicall, verbally, or written. These information are kept properly confidential. This Act 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 required by "HIPAA," 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, autiting functions, cost management analysis and customer service. An example would be an internal quality assessment review. We may also create and distribute reidentified health information by removing all references to individual identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives to other health-related benefits and services that maybe of interest to you.

Any other uses or 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 the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Contract Officer:

- The right to request restrictions on certain issues and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are however, not required to agree to a requested restriction. If we do not agree to a restricition, we must abide by it unless you agree in writtin to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protect health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

(Continued)

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

This notice is effective as of January 1, 2018 and we are required to abide by the 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 make new notice provisions effective for all protected health information that we maintain. You may request a written copy of a revised Notice of Privacy Practices from as needed.

If you feel that your privacy protections have been violated, you have the right to file a written complaint with our office, the Department of Health & Human Services, or Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Privacy Contract Officer: All Smiles Dental, Office Manager

Financial Policy

Our goal is to ensure that each patient receives quality dental care at a fee that is both reasonable and affordable. While your dental needs are more important than financial considerations, we are sure you can appreciate the need of our dental clinic to collect fees to ensure that dental care services are available to area residents.

It is the policy of All Smiles Dental that any portion of our charges not covered by your insurance such as deductibles, co-pays, non-covered services and etc. be paid the same day the service is provided. This portion is only an estimate, based on the insurance breakdown percentages. Any remaining charges due after the claim has been processed will be your responsibility. Payment in full can be made with cash, check, credit card or money order. All Smiles Dental accepts Visa, Master Card, Discover Card and American Express. Non-Sufficient Fund checks are collected electronically and a service charge of $30.00 will be applied to your account for each returned check.

All Smiles Dental will allow 30 days for the bill to be paid without finance charges applied. After 30 days past due, a finance charge will be imposed on any outstanding balances.
The finance charge of 1.5% shall be applied to the current balance per month until resolved.
In some situations, All Smiles Dental can offer third party financing plans to our patients who cannot pay in full on the day of service. However, this service is contingent upon a credit check approval.

Services may be denied due to a delinquent account. **Patients with delinquent accounts will be required to pay cash for services on the date that services are rendered. In some cases, prepayment will be required.** If your account has been placed with a collection agency, they will ask you to make arrangements for payment. Once the account balance has been resolved, we will review the terms under which you may be granted future appointments.

Please do not hesitate to contact our office if you are having difficulty meeting your financial obligation to us. It is our hope that by presenting each patient with this written credit policy, future misunderstandings about the financing of dental care can be avoided.

(Continued)

Initial Disclosure Statement is provided to you in accordance with Regulation Z – Truth in Lending: You will be billed monthly for any outstanding balances for the services we have performed for you.

Finance Charges will begin to accrue (30) thirty-days from the first billing statement. **Finance Charges** will be calculated at a monthly rate equal to 1.5 %, which corresponds to an **Annual Percentage Rate** equal to 18%. If you pay all charges that appear on your monthly statement within (30) thirty-days of the statement date, no **Finance Charge** will be made to your account.

Explanation of Method used to determine the balance in which the finance charge may be calculated: All Smiles Dental figures the Finance Charge on your account by applying the monthly rate to the amount you owe at the end of each billing cycle (including charges for new services and deducting payments and credits made during the billing cycle.)

This notice contains important information about your rights and our responsibilities under the Fair Credit Billing Act: Notify All Smiles Dental of errors or questions about your bill! If you think your bill is wrong, or if you need more information about a transaction on your bill, write to us on a separate piece of paper from the bill and mail to the return address listed as soon as possible. We must hear from you no later than (30) thirty-days after we sent you the first bill on which the error or problem appeared. You may contact us, but doing so will not preserve your rights.

Please send us the following information:Your name and account number

1. The dollar amount of the suspected error
2. Describe the error and explain if you can, why you believe there is an error.
3. If you need more information, describe the item you are not sure of.

Your Rights and Responsibilities after we receive your written notice: We must acknowledge your letter within (30) thirty-days unless we have corrected the error by then. Within (60) sixty-days, we must either correct the error or explain why we believe that bill was correct.

After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount you question, including finance charges and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date it is due

If you fail to pay the amount that we think you owe, we may report you as a delinquent. However, if our explanation does not satisfy you and you write to us within (10) ten-days telling us that you refuse to pay, we must notify those that we report you to that you have a question about your bill. And, we must inform you of whom we reported you to. If the matter is settled and finalized between you and All Smiles Dental, then we must inform those that we reported you to.