

**Patient Information**

Patient Name: \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last First

Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_ Family Status: Single Married Child Other

Social Security Number \_\_\_\_\_ Driver License Number \_\_\_\_\_ State \_\_\_\_\_

Address \_\_\_\_\_  
Street apt# City State Zip

Cell Phone \_\_\_\_\_ Can we text your cellphone? YES NO

E-MAIL \_\_\_\_\_

**Spouse or Responsible Party Information**

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
Last First

Birth Date \_\_\_\_\_ Gender: \_\_\_\_\_ Family Status: Single Married Child Other

Social Security Number \_\_\_\_\_ Driver License Number \_\_\_\_\_ State \_\_\_\_\_

Cell Phone \_\_\_\_\_ Can we text cellphone? YES NO

Can we discuss treatment with spouse or responsible party? YES NO

**Employment Information**

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Referral Information**

Whom may we thank for referring you to our practice? Another patient  driving by  google  Yelp  School  Work  Other

Name of person or office referring you to our practice: \_\_\_\_\_

**FINANCIAL CONSENT AND PAYMENT POLICY**

1. **PAYMENT** Payment is required for all services at the time they are rendered. All applicable copayments, coinsurance, and/or deductibles will be collected at the time of service. Emergency dental services without previous financial arrangements must be paid in full at the time of service.
2. **INSURANCE** Your insurance coverage is a contract between you and your insurance company to help meet your dental expenses. Understanding your insurance benefits is your responsibility. Fees quoted are estimates only. Smile Again Dental can only estimate coverage based on the information you provide. Please contact your insurance company with any questions regarding your benefits. If you are not insured by the plan, payment in full is expected at each visit.
3. **NON-COVERED SERVICES** Please be aware that some or all services provided may be non-covered by your insurance. Payment for these services is due in full at the time of the visit.
4. **CLAIM SUBMISSION** We will submit insurance claims on your behalf and assist you as reasonably possible. Your insurance company may require additional information directly from you. It is your responsibility to comply with their requests. Insurance benefits remain a contract between you and your insurance carrier.
5. **COPAYMENTS AND DEDUCTIBLES** All copayments and deductibles are due at the time services are rendered. This requirement is part of your contract with your insurance company. Failure to collect copayments and deductibles may be considered insurance fraud.
6. **NO INSURANCE** If you do not have insurance coverage, payment in full is required at the time of your visit.
7. **PROOF OF INSURANCE** All patients must complete a patient information form and medical history prior to treatment. We require a copy of a valid photo ID and a current insurance card. Failure to provide accurate insurance information in a timely manner may result in patient responsibility for the balance.
8. **COVERAGE CHANGES** If your insurance coverage changes, please notify our office prior to your next visit so we can update your information accordingly.
9. **NON-PAYMENT** If your account becomes more than 90 days past due, you will receive a notice requesting payment within 30 days. If the balance remains unpaid, your account may be referred to a collection agency.
10. **DEPOSIT** Smile Again Dental may require a 25% deposit for certain dental treatments, due 7 days prior to the appointment. The deposit will be applied toward the balance due at the completion of treatment.

**\*\*\*Appointment Cancellation Policy\*\*\***

To provide the best service to all patients, we kindly request **at least 48 hours' notice** for any appointment cancellation or rescheduling. This allows us to offer the reserved time to another patient in need of care. Failure to provide proper notice, or missing a scheduled appointment without prior notification, may result in a **\$50 cancellation fee** charged to your account.

\*I have read, understand and agree to the Financial Consent and Payment Policy of Smile Again Dental.

\*I understand that charges are not covered by my insurance company, as well as deductibles and copayments are my responsibility.

\*I authorize direct payment of the dental benefits otherwise payable to you, directly to the Smile Again Dental, Talal Aswad, D.D.S.

**Patient Name** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

**Smile Again Dental**

2745 S Alma School Rd Suite#1

Chandler, AZ 85286

Phone: (480) 917-7645

Effective Date: 02/16/2026

This notice describes how your health information may be used and disclosed and how you can access it. Please review carefully. Protected Health Information (PHI) is information that identifies you and relates to your past, present, or future physical or mental health, healthcare services, or payment for services.

**OUR PLEDGE REGARDING YOUR HEALTH INFORMATION** - We are committed to protecting the privacy and security of your protected health information (PHI). We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice
- Notify you if a breach occurs that may have compromised the privacy or security of your information

**HOW WE MAY USE AND DISCLOSE YOUR PHI :**

- **Treatment** – To provide and coordinate your dental care
- **Payment** – To obtain payment for services
- **Healthcare Operations** – For quality assessment, training, compliance, audits, and administration
- **Appointment Reminders** – By phone, text, email, or mail
- **Required by Law** – When disclosure is mandated by law
- **Emergencies** – To protect your health or safety
- **Public Health Activities** – For disease prevention or reporting
- **Research** – When permitted by law with safeguards
- **Legal Proceedings** – In response to lawful processes
- **Business Associates** – Vendors providing services on our behalf
- **Workers' Compensation** – As authorized by law
- **Marketing**- Will not use your PHI for **marketing** without your written authorization.

**SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) RECORDS:** Some health information is considered especially sensitive and receives enhanced protection under federal law, including information related to substance use disorder (SUD). Even if this practice is not a substance use treatment provider, these protections may apply if we receive, maintain, or transmit SUD-related information as part of your health record.

**How SUD Information May Be Used:** SUD-related records may be used and disclosed for treatment, payment, and healthcare operations, as permitted by law, unless you request additional restrictions. Prohibition on Legal Use SUD-related records may not be used against you in criminal, civil, or administrative proceedings without your written consent or a specific court order. Redislosure Limitations -SUD-related information may not be redisclosed unless permitted by law. Additional restrictions may apply beyond standard HIPAA rules. Fundraising Restrictions - Your SUD-related information will not be used for fundraising purposes without your consent. You have the right to opt out of fundraising communications.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION, you have the right to:**

- **Access** – Obtain a copy of your PHI
- **Amendment** – Request corrections to your PHI
- **Accounting of Disclosures** – Receive a list of certain disclosures of your PHI
- **Restrictions** – Request limitations on how we use or disclose your PHI
- **Confidential Communications** – Request communications in a specific manner/location
- **Fundraising Opt-Out** – Opt out of fundraising communications
- **Breach Notification** – Be notified of breaches of unsecured PHI
- **Complaints** – File a complaint with the OCR without retaliation

**To whom may the information be released –**

**Full Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Patient Name** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**GENERAL DENTISTRY CONSENT FORM**

1. **EXAMINATIONS AND X-RAYS** I understand that my initial visit may require radiographs to complete the examination diagnosis and treatment plan. I understand that Smile Again Dental has set standard intervals for radiographs to aid in the diagnosis of oral lesions, decay between the teeth, bone loss, gum disease, cysts, tumors, infections, and impacted teeth.
2. **DRUGS, MEDICATION AND SEDATION** I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or exasperated infection, increased pain, and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills), if applicable. I understand that local anesthesia is utilized to numb tissue for certain dental procedures. I understand that some patients may experience temporary increased heart rate, allergy, soreness, nerve, or blood vessel bruising, tingling, persistent numbness or trauma after a dental procedure. Itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
3. **CHANGES IN TREATMENT PLAN** I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any and all changes in treatment plan as necessary. I understand that any associated laboratory fees are my financial responsibility.
4. **DENTAL PROPHYLAXIS (CLEANING)** I understand the treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. I understand bleeding could last several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted.
5. **FILLINGS** I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling. I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation which may lead to other measures necessary to restore the tooth to normal function.
6. **REMOVAL OF TEETH** Alternatives to removal have been explained to me (root canal therapy crown, periodontal surgery, etc.) and I authorize the Dentist to remove the diseased tooth and any others necessary for reasons in paragraph 3 above. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are: pain, swelling, dry sockets, spread of infection, bleeding, exposed sinuses, fracture of jawbone, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment; the cost of which is my responsibility.
7. **DENTURES • COMPLETE OR PARTIAL** I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges which are my responsibility.

**Patient Name** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**GENERAL DENTISTRY CONSENT FORM**

8. CROWNS, BRIDGES, VENEERS AND BONDING I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease and/or bite problems which may necessitate remake of the crown, bridge, or veneer. I understand that there will be additional charges for remakes or other treatment due to my delaying permanent cementation and/or any complications that may arise during treatment. I understand that any additional costs incurred are my responsibility.
9. ENDODONTIC TREATMENT (ROOT CANAL) I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). After root canal treatment is completed, it is necessary to have the tooth restored within two weeks for optimal success. I understand that the tooth may be lost despite all efforts to save it.
10. PERIODONTAL TREATMENT (TISSUE AND BONE) I understand that I have a serious condition causing gum inflammation and/or bone loss and that It can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations. I understand bleeding could last for several hours. Should bleeding persists particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.
11. BONE GRAFT I understand that the bone graft I will be receiving is derived from human bone that has been collected, stored, and processed according to the standards for Tissue Banking of the American Association of Tissue Banks and Food and Drug Administration Regulations. There have been no reports of disease transmission during the thirty plus year history of using freeze-dried bone for socket preservation.
12. ORTHODONTICS Orthodontics may be prescribed for straightening teeth with a series of clear, removable retainers. Successful outcome is dependent on patient compliance, consistent wearing of the aligners, individual patient physiology, and tooth form. It is important to wear the aligners for at least 22 hours a day and remove the aligners for eating and drinking followed by immediate oral hygiene. Throughout the course of treatment, changes in your bite may occur, and it may take an adjustment phase for you to get used to these changes in your bite, muscles, and joints. You may experience some slight soreness and speech changes which are usually quickly self-limiting. Your impressions, x-rays and photographs are sent to an outside vendor for the treatment planning phase and manufacturing of the aligners. During or after the course of treatment, certain tooth restorations may need to be replaced based on functional or esthetic needs in the newer, more ideal position.
13. NITROUS OXIDE I understand that if I choose to use nitrous oxide during my dental treatment, I have been informed about and understand the possible side effects. These may include, but are not limited to, nausea, vomiting, dizziness, and headache.
14. REFERRALS If a referral is made to a medical or dental specialist, it is the patients' responsibility to follow through with the referral and the specialist's advice.

I have had the opportunity to read this form and to have all my questions answered by my dentist. My signature below signifies that I understand and consent to the treatment plan that is proposed for me, together with any known risks and/or complications associated with the treatment.

**Patient Name** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_