Smile Again DENTAL
family dentistry & orthodontics

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 ______________________________

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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: ______________________________

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FINANCIAL CONSENT TO PAYMENT POLICY

Thank you for choosing Smile Again Dental as your dental provider. We are committed to providing you with quality health care. This document outlines our policy for patient and insurance responsibility for services rendered. Please read it and sign it, a copy will be provided upon request.

1. PAYMENT is required for all services at the time they are rendered. All applicable copayments, coinsurances and /or deductibles will be collected at the time of service. All emergency dental service without previous financial arrangements, must be paid for in full at the time services.

2. INSURANCE. Your insurance coverage is a contract between you and your insurance company to help you meet your dental expense. Knowing your insurance is your responsibility. Fees are ESTIMATES only. Smile Again Dental can only estimate regarding your insurance coverage based on the information you provided. Please contact you insurance company with any questions regarding your coverage. **If you are not insured by a plan, payment in full is expected at each visit**.

3. NON-COVERED SREVICES. Please be aware that some or all of the services you receive may be non-covered .You must pay for these services in full at the time of the visit.

4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company.

5. CO-PAYMENTS AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure of our part to collect co-payment and deductibles from patients can be considered fraud.

6. NO INSURANCE. If you have no insurance, you will be required to pay for your visit in full.

7. PROOF OF INSURANCE. All patients must complete our patient information form and medical history before seeing the provider. We must obtain a copy of your photo ID and a current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim

8. COVERAGE CHANGES. If your insurance changes, please notify us before your next visit, so we can make appropriate changes to help your receive your maximum benefits.

9. NON-PAYMENT. If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

10. DEPOSIT. Smile Again Dental requires a %25 deposit on dental treatment 7 days prior to the appointment. Deposit will be apply to the balance due at the end of your appointment.

11. MISSED APPOINTMETNS. If you do not cancel your appointment at least 48 hours in advance, Smile Again Dental will assess a **$50 missed appointment fee.**

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 deductible and co-payments 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.

Name of patient, parent or guardian ___________________________Relationship to Patient: _________________

Signature ____Date_________________________________

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NOTICE OF PRIVACY PRACTICES (HIPAA)

PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

The Health Insurance Portability and Accountability Act (HIPAA) is a law implementing national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. This form allows the disclosure and authorization of your personal health information to be released to whom you specify. This may include X-Rays, treatment plans, financial records, and other information pertaining to your record with Smile Again Dental. Information disclosed to specified individuals may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Any correspondence should be addressed to:
Smile Again Dental
2745 S. Alma School Rd., Ste. 1
Chandler, AZ 85286

To whom may the information be released - Full name & relationship ___________________________

Patient Name______________________________ Patient/Guardian____________________________

Signature:_________________________________ Date______________________________________

Cancellation Policy

We require 48 hours **cancellation** notice prior to your scheduled arrival date; otherwise we will charge you a **$50 cancellation fee**

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GENERAL DENTISTRY INFORMED CONSENT

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. I authorizes Smile Again Dental to take x-rays, study models, photographs.

2. DRUGS, MEDICATION AND SEDATION I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting. I understand that failure to take medications prescribed for me may offer risks of continued infection, increased pain. I have advised Dr.Aswad of any and all medications I am taking prior to starting dental work that may have unforeseen negative consequences for me. I have informed Dr.Aswad of any known allergies

3. CHANGES IN TREATMENT PLAN I understand that dentistry is not an exact science. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized. 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. I give my permission to Dr.Aswad to make any and all changes in treatment plan as necessary. I understand that any associated 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. 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 understand that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. I understand that cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. It is my responsibility to return for permanent cementation within **21 days** after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease and bite problems which may necessitate remake of the crown, bridge, or veneer. I understand that there will be additional charges or other treatment due to my delaying permanent cementation

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.

8. REMOVAL OF TEETH 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. 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.

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 **IF** I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss and that it can ultimately lead to the loss of my teeth. I understand that any dental procedure may have a future adverse effect on my periodontal. 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

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. NITROUS OXIDE I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness, and headache.

I have had the opportunity to read this form. My signature below signifies that I understand and consent to the treatment plan with any known risks and/or complications associated with the treatment.

Name of Patient: ____

Signature of Patient or Guardian: _________________________ **Date:** ______________________