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 _____

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 services 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 expenses. 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 your 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 SERVICES 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. COPAYMENT AND DEDUCTIBLE All copayments 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 copayments 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 CHANGE If your insurance changes, please notify us before your next visit, so we can make appropriate changes to help you 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 may requires a %25 deposit on dental treatment 7 days prior to the appointment. Deposit will be applied to the balance due at the end of your appointment.

CANCELLATION POLICY

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

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient record, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to the PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request. 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_____ **Parent/Guardian**_____

Signature _____ **Date**_____

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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. I authorize 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 notified.

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, and 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

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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.

Patient Name _____

Signature of Patient or Guardian: _____ **Date:** _____