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

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

To provide the best service to all our patients, we require a 48-hour notice for cancellations or rescheduling of your appointment. This advance notice allows us to offer the appointment time to other patients who may be in need of dental care. **If you do not provide at least 48 hours' notice, or if you miss your scheduled appointment without prior notification, a $50 cancellation fee will be charged to your account.** We appreciate your understanding and cooperation in helping us manage our schedule effectively.

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 also understand that Smile Again Dental has established standard intervals for radiographs to assist in diagnosing 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, and photographs as needed.

2. DRUGS, MEDICATION AND SEDATION I understand that antibiotics, analgesics, and other medications can cause allergic reactions, including redness, swelling of tissues, pain, itching, and vomiting. I also understand that failing to take medications prescribed for me may increase the risks of continued infection and pain. I have informed Dr. Aswad of all medications I am currently taking before starting any dental work that could have unforeseen negative consequences for me. Additionally, I have notified Dr. Aswad of any known allergies.

3. CHANGES IN TREATMENT PLAN I understand that dentistry is not an exact science, and I acknowledge that no guarantee or assurance has been made to me regarding the dental treatment(s) I have requested and authorized. I understand that during treatment, it may be necessary to change or add procedures due to conditions that were not discovered during the initial examination. I give my permission to Dr. Aswad to make any necessary changes to the treatment plan. I understand that any associated fees will be my financial responsibility.

4. DENTAL PROPHYLAXIS (CLEANING) I understand that the treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line, known as periodontal disease. I understand that bleeding could last for several hours. If the bleeding persists, especially if it is severe, I should seek attention and notify this office immediately.

5. FILLINGS I understand that care must be exercised when chewing on fillings, especially during the first 24 hours, to avoid breakage. I also understand that sensitivity is a common aftereffect of a newly placed filling. Additionally, I recognize that a more extensive restoration than originally diagnosed may be required if additional decay or unsupported tooth structure is found during preparation, which may necessitate further measures to restore the tooth to normal function.

6. CROWNS, BRIDGES, and VENEERS AND BONDING I understand that it may not always be possible to match the color of natural teeth exactly with artificial teeth. I also acknowledge that I may be wearing temporary crowns, which can come off easily, and I must take care to keep them in place until the permanent crowns are delivered. I understand that the final opportunity to make changes to my new crown, bridge, or veneer (in terms of shape, fit, size, and color) will be before cementation. I recognize that cosmetic procedures may sometimes lead to the need for future root canal treatment, which cannot always be predicted. It is my responsibility to return for permanent cementation within 21 days after tooth preparation. Excessive delays may result in decay, tooth movement, gum disease, and bite problems, which could necessitate remaking the crown, bridge, or veneer. I understand that there will be additional charges or other treatments required due to delays in permanent cementation.

Patient Name_____ **Signature** _____

Parent/Guardian_____ **Date** _____

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GENERAL DENTISTRY CONSENT FORM

7. DENTURES • COMPLETE OR PARTIAL I understand that full or partial dentures are artificial appliances made from plastic, metal, and/or porcelain. The potential issues associated with wearing these appliances, including looseness, soreness, and possible breakage, have been explained to me. I realize that the final opportunity to make changes to my new denture (such as shape, fit, size, placement, and color) will be during the "teeth in wax" try-in visit. Immediate dentures, placed right after extractions, may initially be uncomfortable and may require several adjustments and relines. A permanent reline or a second set of dentures may be necessary later.

I understand that most dentures will require relining approximately three to twelve months after initial placement, and the cost for this procedure is not included in the initial denture fee. Failure to keep delivery appointments may result in poorly fitted dentures. If a remake is needed due to a delay of more than 30 days, there will be additional charges for which I am responsible.

8. REMOVAL OF TEETH I understand that removing teeth does not always eliminate all infection, if present, and that further treatment may be necessary. I am aware of the risks involved in having teeth removed and acknowledge that complications may arise during or after the procedure. Should complications occur, I may need additional treatment from a specialist or even hospitalization, and I understand that the costs associated with such treatments are my responsibility.

9. ENDODONTIC TREATMENT (ROOT CANAL) I understand that during endodontic (root canal) treatment, there is no guarantee that the procedure will save my tooth. Complications can occur, and occasionally, metal objects may be cemented in the tooth or extend through the root, which does not necessarily impact the success of the treatment. I am aware that additional surgical procedures, such as an apicoectomy, may be necessary after root canal treatment. Once the root canal treatment is completed, it is essential to restore the tooth within two weeks for optimal success. Despite all efforts to save it, I understand that the tooth may still be lost.

10. PERIODONTAL TREATMENT (TISSUE AND BONE) I understand that being treated for periodontal disease indicates a serious condition involving gum and bone inflammation or loss, which can ultimately lead to tooth loss. I recognize that any dental procedure may have a potential adverse effect on my periodontal health. I also understand that the success of any treatment relies in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, maintain a healthy diet, avoid tobacco products, and follow other recommendations provided.

11. BONE GRAFT I understand that the bone graft I may receive is derived from human bone that has been collected, stored, and processed according to the standards set by the American Association of Tissue Banks and the Food and Drug Administration. There have been no reports of disease transmission in the thirty-plus years of using freeze-dried bone for socket preservation.

12. 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.

I have had the opportunity to thoroughly read and review this form. By signing below, I acknowledge that I understand the procedures outlined. I am aware of and accept any known risks and/or complications associated with the treatment. My signature indicates my informed consent and agreement to the outlined treatment and procedures.

Patient Name_____ **Signature** _____

Parent/Guardian_____ **Date** _____