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|  **Patient Information** |
| Date: |       |  |  | [ ] New Patient | [ ] Update |  |
| Patient: |       |       |       |       |       |  |
|  | Last | First | MI | Preferred | Title |  |
|  | [ ] Male [ ] Female | [ ] Child\* [ ] Student\*\* | [ ] Single [ ] Married [ ] Divorced [ ] Widowed |
| \*If Child, provide parent/guardian name(s) below: | \*\*If Student, please complete: [ ] Full-time [ ] Part-Time |  |
|  |       |  |  |       |  |
|  | Parent/Guardian Name(s) |  |  | School/Location |  |
| Patient Date of Birth: |       | Patient SSN: |       |  |
| Address: |       |  |  |
|  | Address Line 1 |  |  |  |
|  |       | Home: |       |  |
|  | Address Line 2 | Cell: |       |  |
|  |       |       |       | Other: |       |  |
|  | City | ST | ZIP Code | Pager: |       |  |
| E-Mail: |       | Fax: |       |  |
| Referral? | [ ] Yes [ ]  No | Referred by: |       |  |
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| **emergency Information** |
| In case of emergency, please provide information for the nearest relative or designated contact person not at the patient’s address: |
|  |       |       | Tel: |       |  |
|  | Name | Relationship |  |  |  |

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| **employment Information** |
| Employer: |       | Occupation: |       |  |
| Address: |       |  |  |
|  | Address Line 1 | Work: |       X      |  |
|  |       | Direct: |       |  |
|  | Address Line 2 | Other: |       |  |
|  |       |       |       | Pager: |       |  |
|  | City | ST | ZIP Code | Fax: |       |  |
| E-Mail: |       |  |  |  |
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| **insurance Information** |
| Subscriber: |       |       |       |       |       |  |
|  | Last | First | MI | Preferred | Title |  |
| Subscriber Date of Birth: |       | Subscriber SSN: |       |  |
| Subscriber Employer: |       |  |
| Patient Relationship to Subscriber: | [ ] Self [ ] Spouse [ ] Child [ ] Other       |  |
| **Primary Insurance Carrier:** |       |  |
| Group/Policy No.: |       | ID No.: |       |  |
| Address: |       | Tel: |       |  |
|  |       | Toll-free: |       |  |
|  |       |       |       | Fax: |       |  |
|  | City | ST | ZIP Code |  |  |  |
| **Secondary Insurance Carrier:** |       |  |
| Group/Policy No.: |       | ID No.: |       |  |
| Address: |       | Tel: |       |  |
|  |       | Toll-free: |       |  |
|  |       |       |       | Fax: |       |  |
|  | City | ST | ZIP Code |  |  |  |

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| **Previous Dentist Information** |
| Dentist: |       | Telephone: |       |  |
| Clinic/Facility: |       |  |
| Address: |       |  |
|  |       |       |       |  |
|  | City | ST | ZIP Code |  |
| Reason for changing: |       |  |
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| **dental history** |
| Oral Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor |
| Date of Last Dental Visit: |       | Treatment Type:  |       |  |
|  |  |  |  |  |
|  |
|  |
| [ ] Y[ ] N | Are you currently having dental discomfort? If yes, explain: |       |  |
| [ ] Y[ ] N | Any unhappy/unpleasant dental experiences? If yes, explain: |       |  |
| [ ] Y[ ] N | Any injuries to mouth/teeth/head? If yes, explain: |       |  |
| [ ] Y[ ] N | Any missing teeth other than wisdom teeth or orthodontic extractions? |  |
| [ ] Y[ ] N | Have missing teeth been replaced? |  |
| [ ] Y[ ] N | Orthodontic appliances now or in the past? |  |
| [ ] Y[ ] N | Gums bleed when brushing or flossing? |  |
| [ ] Y[ ] N | Concerned about gum disease? History of gum disease? [ ] Y[ ] N |  |
| [ ] Y[ ] N | Any concerns about the appearance of your teeth? |  |
| [ ] Y[ ] N | Does it hurt to bite or chew? |  |
| [ ] Y[ ] N | Do you clench or grind your teeth? If so, do you wear a night guard or splint? [ ] Y[ ] N |  |
| [ ] Y[ ] N | Do you want to become a regular continuing care patient in our practice? |  |
| [ ] Y[ ] N | Do you want your mouth properly restored and pain free? |  |
| [ ] Y[ ] N | Does any type of dental treatment make you nervous? If yes, please explain below: |  |
|  |       |  |
| The most important concerns regarding my dental treatment are: |  |
|  |       |  |
| What factors are most important for your satisfaction with our office? |  |
|  |       |  |
| Any additional concerns/comments? |  |
|  |       |  |
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| Child/Minor Patients: Please answer the following questions: |
| [ ] Y[ ] N | Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.) |  |
|  |       |  |
| [ ] Y[ ] N | Any unusual speech habits? If yes, explain: |       |  |
| [ ] Y[ ] N | Any lost teeth? If yes, list: |       |  |
| [ ] Y[ ] N | Does the patient receive assistance with brushing and flossing? If yes, how often? |  |
|  |       |  |
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| **primary physician Information** |
| Physician: |       | Telephone: |       |  |
| Clinic/Facility: |       |  |

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| General Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor |
| [ ] Y[ ] N | Under a physician’s care now? |  |
| [ ] Y[ ] N | Any hospitalization in the past 5 years? |       |  |
| [ ] Y[ ] N | Any serious illnesses/surgeries? |       |  |
| [ ] Y[ ] N | Use tobacco in any form? If Yes, Type: |       |  |
| [ ] Y[ ] N | **Is pre-medication required before dental visits due to heart condition or artificial joint?** |  |
| [ ] Y[ ] N | Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.* |  |
| Female Patients: | [ ] Y[ ] N Currently nursing? | [ ] Y[ ] N Currently pregnant? | Due Date: |       |  |
|  |
| Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? [ ] Y[ ] NIf yes, please describe: |
|  |       |  |
|  |
| Is there anything important about your medical condition we have not asked? [ ] Y[ ] N If yes, please describe: |
|  |       |  |
|  |
| All Patients: Do you have, or have you ever had any of the following? (Check all that apply): | [ ] None |  |
| [ ] Acid Reflux | [ ] Bulimia | [ ] Hearing Problems | [ ] Psychiatric Treatment |
| [ ] ADHD | [ ] Cancer/Malignancy | [ ] Heart Attack | [ ] Radiation/Chemo |
| [ ] AIDS/HIV | [ ] Cerebral Palsy | [ ] Heart Disease | [ ] Respiratory Disease |
| [ ] Anemia | [ ] Chemical Dependency | [ ] Heart Murmur | [ ] Rheumatic Fever |
| [ ] Anorexia | [ ] Chicken Pox | [ ] Hepatitis | [ ] Sinus Problems |
| [ ] Anxiety | [ ] Convulsions | [ ] High Blood Pressure | [ ] Stroke |
| [ ] Artificial Heart Valve | [ ] Depression | [ ] Kidney Disease | [ ] Thyroid Condition |
| [ ] Artificial Joints | [ ] Diabetes | [ ] Liver Problems | [ ] Tuberculosis |
| [ ] Arthritis | [ ] Dizziness/Fainting | [ ] Mitral Valve Prolapse | [ ] Ulcers |
| [ ] Asthma | [ ] Epilepsy/Seizures | [ ] Mononucleosis | [ ] Venereal Disease |
| [ ] Autism/Asperger’s | [ ] Frequent Ear Infections | [ ] Pacemaker |  |
| [ ] Bleeding Disorder | [ ]  Frequent Headaches | [ ] Other – please list: |       |  |
|  |
| All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply): |
| [ ] Aspirin | [ ] Codeine | [ ] Lactose Intolerance | [ ] Sleeping Pills | [ ] None |  |
| [ ] Anesthetic – Local | [ ] Dairy | [ ] Metal Sensitivity | [ ] Sulfa Drugs |
| [ ] Barbiturates | [ ] Latex | [ ] Nitrous Oxide Sedation | [ ] Penicillin/Other Antibiotics |
| [ ] Other – please list: |       |  |
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| **medication information** |
| All Patients: Are you currently taking any of the following? (Check all that apply): | [ ] None |  |
| [ ] Antibiotics/Sulfa Drugs | [ ] Antihistamines/Allergy | [ ] Daily Aspirin | [ ] Blood pressure Medications |
| [ ] Blood thinners | [ ] Cancer/Chemo Medications | [ ] Cortisone/Steroids | [ ] Heart Medication/Digitalis |
| [ ] Insulin | [ ] Nitroglycerin | [ ] Oral Contraceptives | [ ] Osteoporosis Medications |
| [ ] Other Diabetic Medications | [ ] Recreational Drugs | [ ] Thyroid Medications | [ ] Tranquilizers |
| [ ] Other (please list below) |  |  |  |
| **Drug Name** | **Dosage** | **Reason Prescribed** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
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|       |       |       |

**Financial Guidelines**

*We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.*

**Insurance**

**We accept all major dental insurance payments; however, we may not be an “in network” provider for your plan**. If we are not an in-network provider, review your plan details, as in many cases insurance reimbursement is very similar.

* **We are in network for Delta Dental and United Health Care.**
* **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
* **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

**Payments**

* **Patient portion or** **patient co-pay is due at** **the time services are rendered** - unless prior financial arrangements have been made.
* **Payment Information:**
	+ All major credit cards are accepted (Visa, MasterCard, Discover)
* **Balances left over 90 days will incur a 5% monthly charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

 **By signing below, I acknowledge I have read and understand the guidelines above.**

|  |  |
| --- | --- |
| Signature:       | Date:       |

# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2016

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Signature:**        **Date:**

**Relationship to Patient**: [ ] Adult Patient [ ] Parent [ ] Guardian [ ] Other

**Please list any dependent children under the age of 18 also covered by this acknowledgement:**

**1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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[ ]  I give permission for the following communications to be used by Saving People’s Smiles Dental Center **(please check all that apply)**

 [ ]  Cell phone: [ ] Text Message reminders permitted
 [ ]  Home phone [ ]  Work [ ]  E-Mail:

[ ]  I am granting permission for Saving People’s Smiles Dental Center to disclose their identity to anyone who may answer my home, work or cell phone.

[ ]  I am granting permission for Saving People’s Smiles Dental Center to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

 [ ]  Home Phone [ ]  Cell Phone [ ]  Work Phone [ ]  None- please just ask for a call back
 [ ]  Other (Please explain)

**I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments,
treatment, and billing of myself and any dependent children listed above:**

**1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **For Office Use Only:** |
| We were unable to obtain the patient’s written acknowledgement of our Notice of Privacy Practices due to the following reason:[ ]  The patient refused to sign[ ]  Communication barriers [ ]  Emergency situation |
| [ ]  Other – please list:       |

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| **Patient consent- payment authorization – signature on file** |
|  |
| To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.I hereby authorize payment directly to Saving People’s Smiles Dental Center of the dental benefits otherwise payable to me.I hereby authorize Saving People’s Smiles Dental Center to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. **By signing below, I acknowledge that I have read and understand the statements mentioned above.** Signature:       Date:      NO SHOW POLICY FOR SAVING PEOPLE’S SMILES DENTAL CENTEROur dental providers want to make sure you and other patients have access to high quality dental care when you are here for treatment. In order to ensure each patient receives the undivided attention they deserve, please be aware of the following appointment policy.**Scheduled Appointments:** Although we will make every effort to remind you of your upcoming dental appointment, you are ultimately responsible for being in the office at the time you were given for your treatment. **Cancelling/Rescheduling Appointments:** If for any reason you are unable to make your scheduled appointment, we ask that you please call our office at least 24 hours in advance to notify us that you will need to cancel or reschedule your appointment. **Missed Appointments**: Due to the lack of access to dental services in our area, missed or “no-show” appointment are unacceptable to our office. If you miss 1 appointment without proper notice, it will be documented in your chart. If you fail to show for a 2nd appointment, as $25.00 missed appointment fee will be assessed to your account. If you fail a 3rd appointment, you will be assessed another $25.00 missed appointment fee and will ultimately be dismissed from the practice. ***I have read, understand, and agree to the “No-Show” policy for SPS Dental Center.***Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_ |