Smoler Smiles

A Healthier Way to Live

Patient Information

Last Name	First		M.I.
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Birth Date	Age	☐ Male ☐ Female	Preferred Name
☐ Married	☐ Single	☐ Divorced	☐ Widowed
Social Security No.	E-Mail Address		
Name of Employer	Dr. LIC. #		
Responsible Party	Responsible Party Social Security No.		
Name of Spouse (if applicable)	Spouse Social Security No.		
How did you hear about our office?			
In case of emergency: Name	Phone	Email	

Dental Insurance

Primary Insurance		Secondary Insurance	
Insurance Company		Insurance Company	
Group No.		Group No.	
Employer Name		Employer Name	
Insured Name	Date of Birth	Insured Name	Date of Birth
Insured's I.D. #		Insured's I.D. #	
Insured's Soc. Sec. #		Insured's Soc. Sec.	
Relationship to Patient		Relationship to Patient	

Medical Insurance

Primary Insurance		Secondary Insurance	
Insurance Company		Insurance Company	
Group No.		Group No.	
Employer Name		Employer Name	
Insured Name	Date of Birth	Insured Name	Date of Birth
Insured's I.D. #		Insured's I.D. #	
Insured's Soc. Sec. #		Insured's Soc. Sec.	
Relationship to Patient		Relationship to Patient	

Consent for Treatment

a. I authorize the doctor or his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.

b. I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. Photographic, audio or video recordings may be used for the following purposes: Conference presentations, educational presentations or courses, informational presentations, on-line educational courses, or educational videos.

c. I authorize my medical insurance and dental insurance to be billed if applicable.

Patient's Signature_____ Date _____ Witness_____

Parent/ Responsible Party's Signature _____ Relationship to Patient _____

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Smoler Smiles
Dental History

Reason for today's visit	Date of last dental visit
Present/Former General Dentist	Date of last dental X-Rays
Present/Former General Dentist's Address	Dentist's phone
Any previous major dental treatment? ☐ Yes ☐ No When?	

Check (√) if you have had any of the following:

☐ Bad Breath ☐ Bleeding or sensitive gums ☐ Broken filling ☐ Broken tooth ☐ Burning Tongue ☐ Chewing difficulty ☐ Clicking or popping jaw ☐ Complications from extractions ☐ Food between teeth	☐ Clenching / Grinding teeth ☐ Frequent Blisters on lips or mouth ☐ Growth in your mouth ☐ Head or neck injury ☐ Jaw Pain ☐ Loose teeth ☐ Oral Surgery ☐ Orthodontic Treatment ☐ Pain around Ear	☐ Periodontal treatment ☐ Root Canal Treatment ☐ Sensitivity to cold ☐ Sensitivity to hot ☐ Sensitivity to sweets ☐ Sensitivity when biting ☐ Snoring ☐ Sores in your mouth ☐ Unusual sounds in ear while eating ☐ Unpleasant taste
Do you smoke? ☐ Yes ☐ No	Do you chew tobacco? ☐ Yes ☐ No	Clench your teeth? Yes ☐ No

How often do you brush?	How often do you floss?
Are you typically nervous about dental treatment? ☐ Yes ☐ No	If yes, what is your concern?

Medical History

Physician's Name		Date of last visit
Physician's Address		Physician's Phone Number
Have you had any serious illnesses or operations? ☐ Yes ☐ No		If so, what?
(Women) Are you pregnant? ☐ Yes ☐ No	Nursing? ☐ Yes ☐ No	Taking birth control pills? ☐ Yes ☐ No
Have you had any blood transfusions? ☐ Yes ☐ No		If so, what for and when
Medications currently taking. Please list.		Allergies. Please list.

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Medical History

Please check the box for any condition that you have had in the past or have now. (PARENT OR GUARDIAN: If you are completing this form for your child, please indicate your child's health status by checking the appropriate box.)

- ☐ Afib/Heart Arrythmias
- ☐ Alcohol Use/Abuse
- ☐ Allergies (seasonal)
- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Angina
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Back Pain
- ☐ Bisphosphonates
- ☐ Blood Disorder
  Type _____
- ☐ Blood Transfusion
- ☐ Blood Thinners
- ☐ Breathing Difficulties
- ☐ Cancer Type_____
- ☐ Circulatory Problem
- ☐ Cirrhosis
- ☐ Chemotherapy
- ☐ Chronic Cough
- ☐ Colitis/Gastritis
- ☐ COPD
- ☐ Cough Blood
- ☐ Congenital Heart Defect/Lesion
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding/Bruising
- ☐ Fibromyalgia
- ☐ Hay Fever
- ☐ Hearing Problems/hearing Aids
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Pacemaker/Defibrillator
- ☐ Heart Surgery/Transplant
- ☐ Hemophilia
- ☐ Hepatitis Type _____
- ☐ Herpes/Cold Sores
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/Aids
- ☐ HPV (Human Pappiloma Virus)
- ☐ Infective Endocarditis
- ☐ Jaundice
- ☐ Kidney/Urinary Problems
- ☐ Latex Allergy
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Medical Marijuana Use
- ☐ Multiple Sclerosis
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Pregnant/Nursing
- ☐ Psychiatric Care / Mental Illness
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Swollen Ankles/Limbs
- ☐ Stent/Shunt
- ☐ Thyroid/Parathyroid Disease
- ☐ Tobacco Use Cigarettes / Chewing Tobacco
- ☐ Tree Nut Allergy
- ☐ Tuberculosis
- ☐ Tumor/Growth
- ☐ Ulcer
- ☐ Use of Vaporizer/Vape/ECigarette
- ☐ * Any other condition/problem diagnosis/disease:
  _____

Consent

I understand that the above information is necessary to provide me with proper dental care. I have answered all the questions to the best of my knowledge. Should further information be required, you have my permission to ask a respective health care provider or agency, who may release such information to you. You have my permission to disclose health information to insurance companies for the purpose of obtaining payment and determining insurance benefits. I will notify the doctor of any changes in my heath status or medications.

Patient/ Guardian Signature	Date

Smoler Smiles
PAYMENT POLICIES

We are pleased to answer any questions you may have about your bill. While dental benefits vary among the many employer benefit plans, we can often help you understand your coverage. Our payment policies are as follows:

General Policy

1. Payment is due in full on the day you receive dental services. We cannot bill for these services. We accept cash, check, Visa and Master Card.
2. To reserve an appointment time with the dentist, most procedures will require pre-payment of treatment, unless other arrangements have been made. All fees and treatment will be outlined and discussed prior to reserving appointment time.
3. Late balances are charged a service charge of $5 per month. We do not offer in-house payment plans.

I have read and agree to the payment policies of Smoler Smiles. If my credit card is on file, I give my permission to charge my card for balances not covered by my Dental Insurance.

Name _____ Date _____

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. However, due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company prior to any office procedures. We charge what is reasonable and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Also, understand that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit. Please remember that your insurance policy is between you and your insurance company and not between your insurance company and your doctor.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

We will gladly discuss your proposed treatment and answer any question relating to your insurance. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE, do not hesitate to ask us. We are here to help you.

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.

Initial _____

I consent to treatment by Smoler Smiles for myself and/or minor child. I have been provided the practice's statement regarding use and disclosure of my protected health information. I understand I may have a copy of this statement if I request it from the practice's privacy officer.
I authorize the release of any information necessary to process my claims and authorize payment to Smoler Smiles .

Your signature below verifies that you have read and understand this statement, and that all of your questions have been answered.

I understand if I have an unpaid balance to Smoler Smiles and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Smoler Smiles or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Smoler Smiles and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Signature _____ Date _____

Smoler Smiles
GENERAL POLICIES

Appointment Policy

If you are unable to keep your appointment, please let us know at least 24 hours in advance so that we may reschedule the time for another patient. All appointments that are canceled with less than a 24-hour notice will have a $50.00 charge added to your account. Any appointment consuming one hour or more of the doctor or hygienist's time will require pre-payment of treatment to reserve the appointment. Thank you for your understanding in this matter.

Patient Initials: _____

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. Our complete Privacy Practices are available for you to read. A copy is kept in our Patient Waiting Room. You may choose to read that entire document before signing this consent form. We will disclose your health information when we are required to do so by law.

Patient Initials: _____

Patient Rights

You have the right to look at or get copies of your health information, with limited exceptions. If you require copies of x-rays, there is a charge of $35 for this service. We will forward your health information to other health agencies with your written request. We ask that you sign an additional consent form to have your records released. We may disclose appointment reminders to you via postcard, e-mail or text.

Patient Initials: _____

Uses and Disclosure of Health Information

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Healthcare Operations: We may use and disclose your health information for treatment, payment or healthcare operations. These include staff meetings, quality assessments, evaluation of practitioner and provider performance, and conducting training programs.

Persons Involved In Care: In the case that you are incapacitated or there are emergency circumstances, we will disclose health information using our professional judgment to persons involved in your care. We will also use our judgment of your best interests in allowing such persons to pick up medical supplies, x-rays, or other health information.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose you health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Patient Initials: _____

Authorization

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. We reserve the right to change our privacy practices at any time. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Smoler Smiles. We may decline treatment if you revoke this consent. You are entitled to request a copy of this Consent.

Signature Patient/ Guardian _____ Date _____

HIPAA Privacy Act

I consent to receive dental treatment from Smoler Smiles. I hereby authorize payment directly to Smoler Smiles of any dental services performed from the insurance company I provide. I shall be legally responsible for any out of pocket costs, such as co-pays, deductibles and services that may not be a covered benefit under the policy. I authorize Smoler Smiles to release any medical information requested in the course of my treatments to my dental insurance company.

I hereby acknowledge review of the Privacy Statement offered at Smoler Smiles and understand a copy can be provided to me. My signature is authorization for Smoler Smiles staff to contact me according to the following instructions:

Please Check YES or NO for each:

☐Yes ☐No OK to leave message on home, work or cell answering machine regarding my medical condition, prescription refills or billing matters.

☐Yes ☐No OK to leave a message with spouse, guardian or family member regarding any medical condition, prescription refills or billing matters.

Other Instructions if I'm unavailable:

I attest that the above information is correct

Signature of Patient or Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

FOR OFFICE USE ONLY:

PART TWO:

Good Faith Effort to Obtain Acknowledgement of Receipt

Patient refused to sign:

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

Describe the reason why the individual would not sign the form:

_____

_____