SmileMore DENTAL

PATIENT INFORMATION

PATIENT INFORMATION

PATIENT NAME Last First M.I. | SOCIAL SECURITY NUMBER

ADDRESS Street | DATE OF BIRTH | SEX ☐Female ☐Male

City State Zip | HOME PHONE NO. | CELL PHONE NO. | WORK PHONE NO.

E-MAIL | MARITAL STATUS ☐Single ☐Divorced ☐Married ☐Widowed

PREFERRED METHOD OF CONTACT ☐ Home ☐ Cell Phone ☐ Work Phone ☐ E-Mail

RACE ☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Filipino ☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ Other

ETHNICITY ☐ Hispanic ☐ Non-Hispanic

PREFERRED LANGUAGE

2ND/SEASONAL ADDRESS Street City State Zip

EMPLOYER | PATIENTS OCCUPATION

EMPLOYER ADDRESS Street City State Zip

PHARMACY NAME | PHARMACY PHONE NO.

HOW DID YOU HEAR ABOUT US? ☐ Online ☐ Insurance ☐ Employer ☐ Patient/ Friend/Family Name: ☐ Physician Name:

RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.

If patient is child, please indicate if parents are: ☐ Married ☐ Separated ☐ Divorced

NAME | SOCIAL SECURITY NUMBER

ADDRESS Street | DATE OF BIRTH

City State Zip | HOME PHONE NO.

EMPLOYER | EMPLOYER PHONE NO.

EMPLOYER ADDRESS: Street City State Zip

INSURANCE INFORMATION

PRIMARY INSURANCE RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child ☐ Other

NAME OF INSURED | SOCIAL SECURITY NUMBER

INSURANCE NAME | DATE OF BIRTH

INSURANCE ADDRESS Street | City State Zip

EMPLOYER NAME

EMPLOYER ADDRESS: Street City State Zip

SECONDARY INSURANCE RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child ☐ Other

NAME OF INSURED | SOCIAL SECURITY NUMBER

INSURANCE NAME | DATE OF BIRTH

INSURANCE ADDRESS Street | City State Zip

EMPLOYER NAME

EMPLOYER ADDRESS: Street City State Zip

SmileMore DENTAL

MEDICALHISTORY

MEDICAL HISTORY

PATIENT NAME Last	First	M.I.	DATE OF BIRTH

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes, please explain:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, please explain:
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes, please explain:
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes, please explain:
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	

WOMEN

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ALLERGIES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other:

HISTORY

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No			
Convulsions	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No			
Cortisone Medicine	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No			
Have you ever had any serious illness not listed above?				☐ Yes	☐ No	If yes, please explain:					

COMMENTS/QUESTIONS

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: DATE

SMILE EVALUATION SURVEY

Patient Name: _____ Date: _____

PLEASE TAKE A MOMENT TO TELL US ABOUT YOUR SMILE.

When I see a picture of myself, the first thing I notice about my smile is:

Some things I consider attractive in other people's smiles are:

What would you change in the appearance of your teeth/smile?

Please checkmark the statements that apply to you.

- ☐ I wish my teeth were whiter
- ☐ I wish my teeth were straighter
- ☐ There are gaps/spaces that I don't like
- ☐ I think my teeth are too small
- ☐ I think my teeth are too large
- ☐ I think my gums show too much when I smile
- ☐ I don't like my silver fillings or my metal crowns because they make my teeth look dark
- ☐ I've noticed that my teeth are worn, chipped, and/or fractured
- ☐ Because I am not totally pleased with my teeth, I sometimes hesitate to smile
- ☐ I don't really know all the options available to me for enhancing my smile
- ☐ Concerns over what the end-result might look like have been a factor in not having any cosmetic work in my mouth
- ☐Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile

SmileMore DENTAL

TMJ QUESTIONNAIRE

Patient Name: _____ Date: _____

Do you have any TMJ (jaw joint) or facial muscle pain? If yes, please describe.

Do you wake up with headaches? If yes, please describe.

Have your teeth been sore upon awakening?

Do you have ear pain? Shoulder pain? Neck pain?

Has your jaw ever locked where you were unable to open or close?

Do you feel or hear any “clicking” or “popping” in either jaw joints?

Have you been diagnosed with teeth clenching/grinding? If yes, how are you treating the clenching/grinding (nightguard, prescription drug, previous bite adjustment, other)?

SmileMore DENTAL

SLEEP QUESTIONNAIRE

Patient Name: _____ Date: _____

Do you sleep more than 7 hours per night?	☐ Yes	☐ No
Do you wake up during the night?	☐ Yes	☐ No
Do you feel tired throughout the day?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Have you been diagnosed with a sleep disorder?	☐ Yes	☐ No
If yes to question #5, have you used or are you currently using a CPAP, sleep appliance and/or oral medications?	☐ Yes	☐ No

CLINICAL SYMPTOMS

Please check all symptoms that describe your sleep:

- ☐ Excessive daytime sleepiness
- ☐ Insomnia
- ☐ Impaired cognition
- ☐ Mood disorders
- ☐ Morning headaches
- ☐ Witnessed sleep apnea
- ☐ Restless legs
- ☐ Restless or disturbed sleep
- ☐ Snoring
- ☐ Nocturnal choking/gasping

HEALTH HISTORY

Please check all conditions that you have:

- ☐ High blood pressure
- ☐ History of stroke
- ☐ Ischemic heart disease
- ☐ Diabetes
- ☐ Heart failure/cardiovascular disease
- ☐ BMI > 35 (morbid obesity)
- ☐ Abnormal oropharyngeal exam
- ☐ Pulmonary disease

FINANCIAL POLICY

Taking care of you and your family is our top priority. However, when talking about finances, we need to avoid any chance of misunderstanding by being clear with all fees, financial options, and how you have chosen to handle your financial responsibilities. The result of this form is a financial agreement that we ask you to sign and an official representative to sign so that we can both count on clarity in this important matter.

At the onset of your treatment, we will provide you with an estimate of the total fees expected. Please note that this is an estimate only. Treatment may change for a variety of unforeseen reasons. When estimating insurance payments or coverage, we must also stress the word estimate, as insurance companies continue to surprise us at times. If the insurance company pays more than expected, you will receive a refund. If they pay less than expected or deny the expected benefit, you will receive a balance due on your statement. If your insurance denies your eligibility after the fact, the balance becomes your responsibility. We request the balance due within 30 days of the receipt of your statement. You can request a pre-authorization before beginning the treatment.

PAYMENT OPTIONS

☐ **PLAN A: MONTHLY PAYMENT PLANS**
For our patients who want to make monthly payments, we offer short- and long-term financing through CareCredit and Lending Club Financing. A member of our business office team will gladly assist you with the application process.

☐**PLAN B: INSURANCE COVERAGE**
Our goal is to do whatever it takes to help you maximize your insurance benefits, and as a courtesy, we are happy to bill your dental insurance for services. Please remember that the contract for your insurance coverage is between you, your employer, and your insurance carrier, and your estimated portion is due in full the day of treatment, or you may choose Plan B for your estimated patient portion.

☐**PLAN C: SELF PAY**
We accept cash, check*, Debit Card, Discover, Master Card or Visa

INITIAL BELOW

_____ I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-sufficient fund checks must be redeemed with certified funds (cashier's check, money order or cash)

_____ I understand that I have until two business days before my appointment to cancel or reschedule. If I do not show-up for my appointment or cancelled late, a $25 per hour (scheduled appointment time) late cancellation or no-show fee may be charged to my account.

_____ I have chosen the above option and accept full financial responsibility for this account. I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment or coverage. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office. Any insurance claim not paid in full after 60 days from the date of service will become my responsibility to pay at that time

Name of Dependents: _____

_____

_____ _____
Patient/Guardian Signature Date

_____ _____
Financial Coordinator Signature Date

CANCELLATION POLICY

To ensure that each patient gets our attention, we set aside dedicated time for you in our schedule. We remind you of your scheduled appointments via text and email for your convenience. However, if you need to cancel or reschedule, we ask that you call or text our office during business hours.

We understand that unexpected issues can arise, and you may need to cancel an appointment. We respectfully ask you to contact our office for at least two business days. Appointments are in high demand, and your early cancellation will give another patient the possibility to access timely dental care.

Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments.

Missed appointments and last-minute cancellations affect the schedule of the clinicians and take appointments from others in need. To avoid a late cancelation or no-show fee, you must cancel your appointment during regular business hours at least two business days before your scheduled appointment time. If you fail to do so, a $25/hour of scheduled appointment time fee will be charged to your account.

By signing this form, I am acknowledging that I fully understand SmileMore Dental's cancellation policy and accept full financial responsibility for any fee incurred by me due to short-notice cancellation or failed appointment.

Name of Dependents: _____

_____

Patient/Guardian Name	Relationship
Patient/Guardian Signature	Date
Witness Signature	Date

OFFICE USE ONLY

We were unable to obtain the patient's written acknowledgement due to the following reasons:

- ☐Patient refused to sign
- ☐Communication barriers
- ☐Emergency
- ☐Other: _____

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR MARKETING AND PUBLIC RELATIONS

I, _____ hereby grant permission to SmileMore Dental and Imagen Dental Partners, the rights of my image, in video or still, and of the likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to:

- Presentations
- Courses
- Online/Internet Videos
- Media
- News (Press)

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

PATIENT INFORMATION

Patient Full Name: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____

_____ _____

Patient/Guardian Name Date

_____ _____

Patient/Guardian Signature Relationship

If a personal representative executes this authorization, then the authorization must contain a description of the representative's authority to act for the individual, e.g., "parent" or "guardian ad litem"

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Healthcare Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your
confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight
activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regard to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at
- alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2009 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Privacy Officer
John Yu, DDS
12152 N Rancho Vistoso Blvd, Suite 120
Oro Valley, AZ 85755
T: 520.531.8207

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
T: 877.696.6775

PRIVACY AND DISCLOSURE ACKNOWLEDGMENT

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement activities

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.

I _____ give consent for all my protected health information to be shared with:
(Print: Patient or Guardian's Name)

Name _____ Relationship _____

Name _____ Relationship _____

Emergency Phone Number: _____

Dependent family members also covered by this acknowledgement: _____

Person(s) Authorized to bring and approve treatment for dependent family members:

Name _____ Relationship _____

Name _____ Relationship _____

Patient/Guardian Signature _____ Date _____

Relationship to Patient _____

OFFICE USE ONLY

We were unable to obtain the patient's written acknowledgement due to the following reasons:

- ☐Patient refused to sign
- ☐Communication barriers
- ☐Emergency
- ☐Other: _____

AUTHORIZATION TO DISCLOSE DENTAL HEALTH INFORMATION

I, the undersigned, authorize SmileMore Dental to disclose the information described below to the recipient(s) described below. I understand and agree to the statements and information contained in this authorization.

PATIENT INFORMATION

Patient Full Name: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Other Names During Treatment: _____

RELEASE INFORMATION

Please complete this section and check mark next to the appropriate to/from box for the request to be processed:

☐ Release Information to ☐ Request Information From

Name/Facility: _____ Attention: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose of Request _____

INFORMATION TO BE RELEASED

Please provide information in my dental health records for dates: From: _____ To: _____

Place a check mark next to the requested records:

☐ Complete dental chart ☐ Dental Radiographs Other: _____

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Place a check mark next to the requested records:

☐ Complete dental chart ☐ Dental Radiographs Other: _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

_____ _____

Patient/Guardian Name Date

_____ _____

Patient/Guardian Signature Relationship

If a personal representative executes this authorization, then the authorization must contain a description of the representative's authority to act for the individual, e.g., "parent" or "guardian ad litem"

SmileMore Dental
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