SmileMore Dental, PC

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsilitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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:

X_____ Date:_____

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

*

*

ORTHODONTIST

ORTHO START DATE

ORTHO END DATE

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

SmileMore Dental, PC

General and Cosmetic Dentistry

Name: _____ ***Date:*** _____

SMILE EVALUATION SURVEY

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 of 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, PC
12162 N. Rancho Vistoso, Ste. 140
Oro Valley, AZ 85755
Ph) 520.531.8207
www.smilemoredentalaz.com

TMJ QUESTIONNAIRE

Name: _____ ***Date:*** _____

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

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

3. Have your teeth been sore upon awakening?

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

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

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

7. 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

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Sleep Questionnaire

Name:_____

Date:_____

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

7. 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

8. Health history – Please check all conditions that you may have.

_____High blood pressure	_____History of stroke
_____Ischemic heart disease	_____Diabetes
_____Heart failure/Cardiovascular disease	_____BMI > 35 (morbid obesity)
_____Abnormal oropharyngeal exam	_____Pulmonary disease

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Fax) 520.531.8304
www.smilemoredentalaz.com

FINANCIAL OPTIONS & ARRANGEMENTS

Taking care of you and your family is our top priority. That's why, when it comes to talking about finances, it's very important for us 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 office 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 understand that it will be an ***estimate*** **only**. Treatment sometimes changes for a variety of unforeseen reasons. When it comes to 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, a balance due will be reflected on your statement. If they deny your eligibility after the fact, the balance becomes your responsibility. We do request the balance due within 30 days of your receipt of your statement.

Thank you for reviewing our financial options and indicating your choice of payment. We appreciate the confidence you have placed in us in caring for you and your family and remain available to you at any time to assist you with your account. Again, please feel free to contact us with any questions regarding the payment options listed below.

PAYMENT OPTIONS

□ **PLAN A: SmileMore Membership** – For our patients not utilizing an Insurance Plan, this is an in house plan – please ask our business team for more information.

□ **PLAN B: 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 C: 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 that your estimated portion is due in full the day of treatment, or you may choose Plan B for your estimated patient portion.

□ **PLAN D: Self Pay –** We accept cash, check, Debit Card, Discover, Master Card or Visa

**** We do apply a $35.00 NSF fee for any returned check****

I, _____, have chosen option _____ above, 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.

Names of dependents: _____

_____

Patient / Guardian Signature: _____ Date: _____

Financial Coordinator Signature: _____ Date: _____

If for any reason you need to change your appointment, please remember to inform our office as soon as possible so other patients can use this time – we do request a minimum of two [2] working days notice

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

SmileMore Dental, PC
12162 N. Rancho Vistoso Blvd., Ste. 140
Oro Valley, AZ 85755
Ph) 520.531.8207

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.

Patient Name: ______________________________ Date: ______________________

Signature: _________________________________

Relationship to Patient: ______________________

Dependent family members also covered by this acknowledgement:

____

____

- -

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

NOTICE OF PRIVACY PRACTICES
SmileMore Dental, PC

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.
- **Health Care 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 regards 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 April 14, 2003, 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 S. Yu, DDS
12152 N. Rancho Vistoso Blvd., Ste. 120
Oro Valley, AZ 85755
Ph) 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, S.W.
Washington, D.C. 20201
Ph) 877.696.6775 (toll-free)

Authorization to Release Dental Information

SmileMore Dental, PC
John S. Yu, DDS
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Oro Valley, AZ 85755
Ph) 520.531.8207
Fax) 520.531.8304
www.smilemoredentalaz.com

The execution of this form does not authorize the release of information other than that specifically described below.

To:[current dentist] _____ **Phone#:** _____ **Fax#:** _____

Patient:
_____

Date of Birth: _____ **SSN:** _____

RELEASE TO: SmileMore Dental, PC [e-mail - smilemore@smilemoredentalaz.com]

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency, or individual named in this request. I understand that the information to be released includes information regarding the following condition[s]:

_____ Drug Abuse, if any
_____ Sickle Cell Anemia, if any
_____ Alcoholism or alcohol abuse, if any
_____ Psychological or psychiatric condition, if any

Information requested:
_____ Copy of complete dental chart
_____ Copy of dental radiographs
_____ Other [models, etc.] describe: _____

Purpose or need for which information is to be used:
_____ Transfer of records
_____ Second opinion
_____ 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.

Print Name: _____ **Date:**
_____

Signature: _____ **Relationship to Patient:**
[Patient or Legal Guardian]