# CompleteSmiles

Patient Paperwork

## Patient Information

Name: _____ Sex: _____ Pronouns: _____

Preferred Name: _____ DOB: _____ SSN: _____

Employer: _____ Referral? _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Email: _____ Date: _____

Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Minor

### Emergency Contact Information

Name: _____ Phone: _____

Relationship to Patient: _____

### Responsible Party (if different from patient)

Name of person responsible for account: _____

Relationship to Patient: _____ DOB: _____ SSN: _____

Address: _____ City: _____ Zip: _____

Phone: _____

### Dental Insurance Information

Name of the Policy Holder: _____

Relationship to Patient: _____ DOB: _____ SSN: _____

Insurance Company: _____

Policy ID: _____ Group Number: _____

Employer: _____

Signature: _____ Date: _____

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## Dental and Medical History

**Height:** _____ **Weight:** _____

### Please check any of the following that apply to you currently:

- ☐ Sensitivity (hot, cold, sweet ect.)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, or neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifted teeth
- ☐ Bad breath or bad taste in your mouth

### Previous Dentist

**Name:** _____

**City:** _____ **State:** _____

**Reason for leaving:** _____

### If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match

### Please share the following dates:

**Most recent cleaning:** _____

**Most recent complete x-rays:** _____

**Last oral cancer screening:** _____

### Please check any of the following that apply to you:

- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/Aids
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Parkinson's
- ☐ Anxiety
- ☐ Depression
- ☐ ADHD
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any others we may need to know:

_____

_____

Pregnancy and Birth Control:

☐ Pregnant ☐ On Birth Control ☐ Breast Feeding

**Preferred Pharmacy:** _____

**Medication Allergies:** _____

**List any Metal or Latex allergies:** _____

**Signature:** _____

By signing I certify all the information above is complete and accurate

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## Financial Policies

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the cost incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged to their dental insurance. The patient is responsible for paying the estimated co-payment at each dental appointment. This office will help prepare the insurance forms of our patients and assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render service on the assumption that our charges will be paid in full by an insurance company. A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service, unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I agree to pay the fees charged for the dental services provided to the dentist of his/her assignee at the time the services are rendered. I further agree to pay the remaining balance plus reasonable attorney fees, court costs, and a collection agency fee of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

I authorize the dentist and his assignees to release financial identifiable information and treatment descriptions and information, either electronically, by facsimile, or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have read a copy of this office's privacy policies. I agree to disclose to the dentist names of any individuals whom I authorize the dentist to discuss my dental care.

- We reserve the right to charge a $50.00 fee for any appointment cancelled without 48 hours notice and a $25.00 fee for any returned checks.

- I acknowledge that treatment plans are ESTIMATES ONLY and are based on information given by my insurance company and me. All treatment costs remain my responsibility and I promise to pay my account, regardless of insurance coverage.

If patient is 15 minutes late to his/her appointment, then appointment may have to be rescheduled.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

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

**Signature:** _____

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## Notice of Privacy Practices

**This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.**

We have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of our services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the phone.

In an emergency, we may disclose your health information to a family member of another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.
You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Please give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change in your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
If we change any of the details of this notice, we will notify you of the changes in writing. You have the right to receive a copy of the notice.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (801)943-9090. This notice goes into effect as of April 4, 2003.

Acknowledgment: I have read a copy of this Notice of Privacy Practices.

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

**Signature:** _____