Smile Design
Implant Centers
CREATING CONFIDENCE WITH EVERY SMILE.

Patient Name: _____ _____ _____
Last Name First Name Initial

Mailing Address: _____

City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____
Sex: M ☐ F ☐ Age: _____ Birthdate: _____
Patient Employed by: _____
Occupation: _____
Business Address: _____
City: _____ State: _____ Zip: _____
Business Phone: _____
Notify in case of emergency: _____ Relationship to Patient: _____
Home Phone: _____ Cell Phone: _____
Business Phone: _____

FINANCIAL INFORMATION

Person Responsible for Account: _____ _____
First Name Last Name
Relationship to Patient: _____
Birthdate: _____ Social Security #: _____
Address (if different than patient): _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
Person Employed by: _____
Occupation: _____
Business Address: _____
City: _____ State: _____ Zip: _____

MEDICAL HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Sex: M / F Height: _____ Weight: _____

Referred to by: _____ Pharmacy: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes ◯ No ◯
2. Has there been any change in your health in the past year? ..... Yes ◯ No ◯
3. My last physical exam was on _____ / _____ / _____
4. Are you now under the care of a physician? ..... Yes ◯ No ◯
   If so, for what condition? _____
5. The name address and phone number of my medical physician is: _____

6. Have you had any serious illness, operation, or hospitalization within the past 5 years? ..... Yes ◯ No ◯
   If so, please describe _____
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes ◯ No ◯
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia or Zometa)? ..... Yes ◯ No ◯
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes ◯ No ◯
   If so, please list: _____
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves, or heart murmur ..... Yes ◯ No ◯
    b. Rheumatic Heart Disease ..... Yes ◯ No ◯
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes ◯ No ◯
       1. Chest pain upon exertion? ..... Yes ◯ No ◯
       2. Shortness of breath after mild exercise? ..... Yes ◯ No ◯
       3. Do your ankles swell? ..... Yes ◯ No ◯
    d. Allergies or hay fever ..... Yes ◯ No ◯
    e. Sinus trouble ..... Yes ◯ No ◯
    f. Asthma ..... Yes ◯ No ◯
    g. Fainting spells or seizures ..... Yes ◯ No ◯
    h. Diabetes ..... Yes ◯ No ◯
    i. Hepatitis, jaundice or liver disease ..... Yes ◯ No ◯
    j. Frequent or recurring mouth sores ..... Yes ◯ No ◯
    k. Thyroid problems ..... Yes ◯ No ◯
    l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes ◯ No ◯
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes ◯ No ◯
    n. Osteoporosis ..... Yes ◯ No ◯
    o. Stomach ulcer or hyperacidity ..... Yes ◯ No ◯
    p. Kidney trouble ..... Yes ◯ No ◯
    q. Tuberculosis ..... Yes ◯ No ◯
    r. Persistent cough or cough that produces blood ..... Yes ◯ No ◯
    s. Persistent swollen neck glands ..... Yes ◯ No ◯

t. Low blood pressure ..... Yes ◯ No ◯
u. Epilepsy or neurological disorder ..... Yes ◯ No ◯
v. Cancer..... Yes ◯ No ◯
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes ◯ No ◯

11. Have you had abnormal bleeding? ..... Yes ◯ No ◯
a. Have you ever required a blood transfusion?..... Yes ◯ No ◯
12. Do you have any blood disorder such as anemia? ..... Yes ◯ No ◯
13. Have you ever had treatment for a tumor or growth? ..... Yes ◯ No ◯
14. Have you had radiation therapy to the head, neck or jaws?..... Yes ◯ No ◯
15. Are you allergic to or have you had a reaction to:
a. Local anesthetics ..... Yes ◯ No ◯
b. Antibiotics (please list)..... Yes ◯ No ◯
c. Sulfa drugs ..... Yes ◯ No ◯
d. Barbiturates or sleeping pills (please list) ..... Yes ◯ No ◯
e. Aspirin ..... Yes ◯ No ◯
f. Iodine ..... Yes ◯ No ◯
g. Codeine or other narcotics (please list) ..... Yes ◯ No ◯
h. Latex or rubber products ..... Yes ◯ No ◯
i. Other ..... Yes ◯ No ◯
16. Have you had any serious trouble associated with previous dental treatment?..... Yes ◯ No ◯
If so, explain: _____
17. Do you have any other condition or disease you think the doctor should know about?..... Yes ◯ No ◯
If so, explain: _____
18. Do you smoke or chew Tobacco? ..... Yes ◯ No ◯
How much? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes ◯ No ◯
20. Are you wearing contact lenses? ..... Yes ◯ No ◯
21. Are you wearing removable dental appliances? ..... Yes ◯ No ◯
22. Do you wish to talk with the doctor privately about anything?..... Yes ◯ No ◯

Women

20. Are you pregnant or trying to become pregnant ..... Yes ◯ No ◯
21. Do you have problems associated with your menstrual period?..... Yes ◯ No ◯
22. Are you nursing? ..... Yes ◯ No ◯
23. Are you taking birth control pills?..... Yes ◯ No ◯

Chief Dental Complaint: _____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient's Signature: _____ Date: _____
(or guardian if patient is a minor)

_____ _____
Print name of person completing form Relation to patient

Date: _____ **Dr's Signature:** _____

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: 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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. Please feel free to ask questions if there is anything you do not understand.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, (please print name) _____, have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care.

Spouse: _____

Parent: _____

Other: _____ _____

_____ _____

SIGNATURE

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY. YOU MAY TAKE THIS COPY IF YOU WISH TO DO SO.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a dentist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be computer technology support.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

□	For medical treatment	☐	For research
□	To obtain payment for our services	☐	To avert a serious threat to health or safety
□	In emergency situations	☐	For organ and tissue donation
□	For PATIENT appointment reminders	☐	For workers' compensation programs

□ To run our Practice more efficiently and ensure all our patients receive quality care

□ In response to certain requests arising out of lawsuits or other disputes

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you by phone or in writing to provide appointment reminders or information about treatment alternatives or other health-related benefits and services

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 may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a requested restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket" in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of January 1, 2014, and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. You may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Financial Questions and Answers

At Smile Design Implant Centers, we want you to be completely clear on the financial commitment that accompanies your surgery. We wish to reduce your financial anxiety by letting you know in advance the cost of your surgery, and we will discuss ways to help you fulfill your financial commitment.

- ***I have dental insurance. Will you bill my insurance? How much do I need to pay?***

  We will help you bill all insurance carriers**, but we are not contracted with any dental plans**. Many plans pay us well even if we are not contracted, **but it is your responsibility to know the details of your plan.** You are responsible for payment in full on your first visit. We will help you bill your insurance.

- ***Do you take Medicare/Medicaid?***

  Smile Design Implant Centers is **not a Medicare/Medicaid provider**. We therefore **cannot** bill Medicare/Medicaid, and Medicare/Medicaid patients scheduling for surgery need to sign a private contract and pay in full.

  We accept cash, money orders, cashier's checks, VISA, MasterCard, American Express and Discover.

- ***Do you offer discounts for cash payments, seniors, or multiple family members?***

  Sorry—we do not offer discounts. Our patients pay the same amounts for the same procedures.

- ***What if I forget to bring my payment in full on the day of surgery?***

  Because it is our policy to receive payment prior to surgery, you will be rescheduled.

- ***What if I reschedule or cancel my surgery?***

  If you give **24 hours' notice**, there will be no charge. If you do not give **24 hours' notice**, there will be a $1000 charge for local anesthesia surgeries.

  If you have any questions, please call the office.

I have read and understand the financial policy above.

Date _____

Print Name _____ Signature _____