We are pleased that you have selected us to provide dental care for you and your family.
Who may we thank for referring you to our office? _____

Patient Information

Date: _____ Patient's name: _____ (Last) _____ (First) _____ (Middle)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip) Cell Phone: (___) _____

Home phone: (___) _____ Social Security # _____ - _____ - _____ Driver's License # _____

Email address: _____

Birth date: ___/___/___ If patient is a minor, give parent's/guardian's name: _____

If patient is a full-time student, fill in school name: _____

Name of nearest relative not living with you: _____ Relationship: _____

Complete address: _____ Phone: (___) _____

Emergency contact: _____ Phone: (___) _____

Responsible Party Information

Name: _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status)

Residence: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address? _____ Home phone: (___) _____ Work phone: (___) _____

Previous address (if less than 3 years): _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security # _____ - _____ - _____ Birth date: ___/___/___ Relationship to patient: _____

Employer: _____ Occupation: _____ No. years employed: _____

Employer address: _____

Social Security # _____ - _____ - _____ Birth date: ___/___/___ Work phone: (___) _____

Insurance Information

Insured's name: _____ Insured's Social Security # _____ - _____ - _____

Insurance company: _____ Group No. _____

Insurance company address: _____ Phone # (___) _____

Is policy connected with your union? Yes___ No ___ Name of union: _____ Local No. _____

Do you have dual coverage? Yes___ No ___ If yes: Please complete the following secondary insurance information.

Insured's name: _____ Insured's Social Security # _____ - _____ - _____

Insurance company: _____ Group No. _____ Local No. _____

Insurance company address: _____ Phone # (___) _____

Insured's employer: _____ Phone # (___) _____

Oral Information

Do your gums bleed when your brush? Yes _____ No _____

Are your teeth sensitive to heat or cold? Yes _____ No _____ Pressure Yes _____ No _____ Sweets Yes ____ No ____

Do you grind or clench your teeth? Yes _____ No _____

Do you have any fear of dental work? Yes _____ No _____

Date of last dental examination _____ What was done at that time? _____

_____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

DENTAL TREATMENT CONSENT FORM

☐ 1. **WORK TO BE DONE**

I understand that I am having the following work done: Fillings_____ Bridges _____Crowns _____Extractions
Impacted teeth removed_____General Anesthesia _____ Root Canals_____Exam + X-Rays _____

(Initials_____)

☐ 2. **DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

(Initials_____)

☐ 3. **CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials_____)

☐ 4. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials_____)

☐ 5. **CROWN, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

(Initials_____)

☐ 6. **DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials_____)

☐ 7. **ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials_____)

☐ 8. **PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth _____

1. Yes/No Is your general health good? _____
   If NO, explain: _____

2. Yes/No Has there been a change in your health within the last year? _____
   If YES, explain: _____

3. Yes/No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____

4. Yes/No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam: _____ Reason for exam: _____

5. Yes/No Have you had problems with prior dental treatment? _____
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____

6. Yes/No Are you in pain now: _____
   If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle yes or no for each)

Yes/No	Chest pain (angina)	Yes/No	Blood in stools	Yes/No	Frequent vomiting
Yes/No	Fainting spells	Yes/No	Diarrhea or constipation	Yes/No	Jaundice
Yes/No	Recent significant weight loss	Yes/No	Frequent urination	Yes/No	Dry mouth
Yes/No	Fever	Yes/No	Difficulty urinating	Yes/No	Excessive thirst
Yes/No	Night sweats	Yes/No	Ringing in ears	Yes/No	Difficulty swallowing
Yes/No	Persistent coughs	Yes/No	Headaches	Yes/No	Swollen ankles
Yes/No	Coughing up blood	Yes/No	Dizziness	Yes/No	Joint pain or stiffness
Yes/No	Bleeding problems	Yes/No	Blurred vision	Yes/No	Shortness of breath
Yes/No	Blood in urine	Yes/No	Bruise easily	Yes/No	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle yes or no for each)

Yes/No	Heart disease	Yes/No	AIDS/HIV	Yes/No	Psychiatric care
Yes/No	Family history of heart disease	Yes/No	Surgeries	Yes/No	Osteoporosis
Yes/No	Heart attack	Yes/No	Hospitalization	Yes/No	Thyroid disease
Yes/No	Artificial joint	Yes/No	Diabetes	Yes/No	Asthma
Yes/No	Stomach problems or ulcers	Yes/No	Family history of diabetes	Yes/No	Hepatitis
Yes/No	Heart defects	Yes/No	Tumors or cancer	Yes/No	Sexually transmitted disease
Yes/No	Heart murmurs	Yes/No	Chemotherapy	Yes/No	Herpes
Yes/No	Rheumatic fever	Yes/No	Radiation	Yes/No	Canker or cold sores
Yes/No	Skin disease	Yes/No	Arthritis, rheumatism	Yes/No	Anemia
Yes/No	Hardening of arteries	Yes/No	Emphysema or other lung disease	Yes/No	Liver disease
Yes/No	High blood pressure	Yes/No	Kidney or bladder disease	Yes/No	Eye disease
Yes/No	Seizures	Yes/No	Stroke	Yes/No	Transplants
Yes/No	Cosmetic surgery	Yes/No	Eating disorders	Yes/No	Tuberculosis

III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle yes or no for each)

Yes/No	Aspirin	Yes/No	Valium	Yes/No	Tetracycline
Yes/No	Darvon	Yes/No	Demerol	Yes/No	Vicodin
Yes/No	Codeine	Yes/No	Penicillin	Yes/No	Percodan
Yes/No	Latex	Yes/No	Food	Yes/No	Nitrous oxide
Yes/No	Local anesthetic (Novocain or Xylocaine)	Yes/No	Erythromycin	Yes/No	Metal

Patient / Guardian Signature *Date*

IV. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING? (Please circle yes or no for each)

Yes/No	Recreational Drugs	Yes/No	Tobacco in any form	Yes/No	Antibiotics
Yes/No	Over-the-counter medication	Yes/No	Alcohol	Yes/No	Supplements
Yes/No	Weight loss medication	Yes/No	Bisphosphonate (Fosamax)	Yes/No	Aspirin

Please list medications you are taking at this time: _____

V. WOMEN ONLY (Please circle yes or no for each)

Yes/No Are you or could you be pregnant? If YES, what month? _____

Yes/No Are you nursing?

Yes/No Are you taking birth control pills?

VI. ALL PATIENTS (Please circle yes or no for each)

Yes/No Do you have or have you had any other disease or medical problems NOT listed on this form?
If YES, please explain: _____
_____

Yes/No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes/No Have you ever taken Fen-Phen? If YES, when: _____

Yes/No Is there an issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omission that I may have made in the completion of this form.

Signature of Patient (Patient or Guardian)	Date	Signature of Dentist	Date
_____	_____	_____	_____

MEDICAL UPDATE

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS

PATIENT CONSENT FORM

- Posted in our lobby is our *Notice of Privacy Practices.* It provides information about how our office may use and disclose your Protected Health Information (PHI);

  You have the right to review our *Notice of Privacy Practices* before signing this *Patient Consent Form.* Please take the time to do so now. A copy is attached.

  You have the right to request that we restrict how your PHI is used or disclosed for Treatment, Billing/Payment, or Dental Office Operations. *Request for Restriction of PHI* must be submitted to the OCP in writing and signed by you as specified in our *Notice;*

  - Our office does not have to agree with your *Request for Restriction of PHI.* If we agree to your *Request for Restriction of PHI,* we shall honor that agreement.

  You have the right to revoke this *Patient Consent Form. Revocation of Consent* must be submitted to the OCP in writing and signed by you as specified in our *Notice;*

  - *A Revocation of Consent* does not affect disclosures made prior to the date the *Revocation was made.*

- Our *Notice of Privacy Practices* may change from time-to-time. If it does, you will receive a "revised" *Notice* on the first visit after changes to the *Notice* were made.
- **Your signature below** signifies your consent to the use and disclosure of your PHI by our office during Treatment, Billing/Payment, and Dental Office Operations as outlined in our *Notice.*
- Our office may condition dental treatment upon execution of this *Patient Consent Form.*
- This Form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Patient Consent was signed by: _____ _____
(Print Name of Patient or Representative) (Relationship to Patient)

_____ ____/____/____
Patient's Signature Date

Witnessed by: _____ _____
(Print Name of Privacy Officer of Office Contact Person) (Title)

_____ ____/____/____
Signature Date

HS-007

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:_____

You have the right to refuse to sign this Acknowledgement

I,_____ , have
(Signature of Patient)

received a copy of this office's ***NOTICE OF PRIVACY PRACTICES*** as required by federal law.

_____
Print Patient's Name

_____
Patient's Signature

FOR OFFICE USE ONLY

On the date above we made a "good faith effort" to obtain written acknowledgement of receipt of our ***NOTICE OF PRIVACY PRACTICES.*** We were unable to obtain acknowledgement for the following reason:

☐ Patient refused to sign

☐ Other _____
(Possible reasons: Language difficulty, communication barriers, dental emergency)

_____ _____
(Printed Name) (Signature of employee attempting to gain acknowledgement)

Office Policy

Dear Patients:

Welcome to our office. We will do our best to make your visit as comfortable as possible. We are pleased that you have chosen our office for your dental health care needs. We strive to provide our patients with high quality comprehensive dental care at a reasonable fee.

On your first visit expect:
A thorough examination and review of your oral health, including necessary x-rays. Cleanings are not done on the first visit.

Your recommended treatment will be explained and you will receive an estimate of your cost according to your particular insurance plan.

After this initial appointment, you may schedule a return appointment to begin your dental treatment. Charges are due and expected on the date of service. For your convenience, we offer a credit service. Ask for information at the front desk.

As a courtesy to our patients, we will confirm your appointment prior to the day of your appointment. The same courtesy is expected from you should there be a need to change or cancel your appointment. We ask that you contact our office within (48) hours to avoid a charge of $25.00 for broken appointments.

X-rays will be released upon signed authorization and a fee of $20.00 (per member) will be charged.

I have read and understand the above policy.

Signature _____ Date _____

CHILDREN AND MINORS

If your child is scheduled for a dental appointment and is under the age of 18, a parent or guardian must be **present and in the office for the entire appointment.** If the parent or guardian leaves the office at anytime during the scheduled appointment the office will stop all scheduled treatment until the parent or guardian returns and rescheduling may be required.

REFUND POLICY

In the event you choose to terminate treatment, there will be a charge of 10% for cash patients and 15% charge for credit card and care credit holders for processing fees. Patient will also be responsible for any lab fees that were incurred. If given a discount for treatment plan and you pay in full and choose not to follow through with treatment, then the treatment that has been completed will be charged out at our UCR fees. Patient refunds take 30 business days to process.

Please understand that all dental services provided to you and your family is charged directly to the patient. We will bill your insurance for services that are performed and carry the outstanding balance for you until the claim is paid as a courtesy. When we receive payment on your dental claim or claims, any unpaid portions by the insurance will become your responsibility and we will bill your accordingly.

Our offices may close any insurance claim that goes for more than 90 days without payment and you will be responsible for the balance on the claim and will have to contact your insurance company for reimbursement.

We would like to remind patients, that just because you have insurance, it doesn't mean that they pay 100% of your fees. We will do our very best to answer any questions that you may have. Ultimately, it is the patient's responsibility to know how your policy works. All estimates to patients are just estimates. We do pride ourselves on our ability to provide you with an estimate of patient portions and insurance portions. These estimates that we provide are approximately 95% accurate.
Insurance is not a guarantee of payable benefits. A claim payment is determined once the insurance company has received a claim and it has been reviewed by your policy for eligibility based on frequency limitations, percentage of coverage, activation of policy at time of service, and overall dental decision. Thank You!!

Signature _____ Date_____

HEMET SMILES

Financial Policies

I certify that the insurance information is correct and true, and that I am eligible for dental coverage. I understand that if the information is **NOT** true or I am **NOT** eligible under the terms of my Dental Subscriber Insurance Agreement, I am liable for all charged services rendered. Also, if the information is **NOT** true, I agree to pay in full for all services received within thirty **(30) days** of receiving a bill from **HEMET SMILES.** Not all services may be covered under your particular insurance plan. Since your insurance company and coverage plan were your choice, all services not covered are your responsibility. Payments for rendered services, unpaid deductibles, and co-payments are due at time of service.

I directly assign all dental benefits to **HEMET SMILES** and understand that I am personally financially responsible for all charges whether or not paid by my insurance. I herby authorize **HEMET SMILES** to release all information necessary to secure payments of benefits. I agree that a photocopy of this agreement be as valid as the original.

I also understand that I will be charged for a broken appointment fee based on the amount of the Doctor's time put aside for my appointment. Our policy is to charge **$25 for minor treatment** (fillings, extractions, cleanings, exams, and consults) if not notified **24 hours** prior to the appointment and **$50 for major treatment** (bridges, crowns, dentures, root canal by gp and oral surgery) if not notified **48 hours** before the appointment time and **$100 for specialist** if not notified **72 hours** prior to appointment. This amount must be paid before any further care is given.

I understand that it is my responsibility as the patient to inform **HEMET SMILES** of any changes in my dental coverage prior to any appointments I may have scheduled.

Thank you for understanding our policies; please let us know if you have any questions.

Name of Subscriber_____ **Subscriber DOB**_____

Subscriber SS#_____ **Subscriber Employer**_____

Patient Name_____ **Patient DOB**_____

Insurance Plan_____ **Plan/Group #**_____

Patient Signature_____ **Date**_____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act—45 CFR Parts 160 and 164)

1. I hereby authorize _____ to use and/or disclose the
[Name of Health Care Provider]
protected health information described below to _____.
[Name of Individual]

2. Authorization for Release of Information. Covering the period of health care from

☐ _____ to _____ **OR** ☐ all past, present and future periods:

a. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. ☐ I hereby **authorize the release of my complete health record with the exception of the following information:**

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until _____, at which time this authorization expires.
[Date or Event]

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

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