SMITH FAMILY DENTISTRY

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Mailing Address _____
STREET Apt #

_____
CITY STATE ZIP

Phone: Home (_____) _____ Spouse/Parent Name: _____

Work (_____) _____

Mobile(_____) _____

E-Mail _____ Emergency Name: _____

Employer _____ Emergency Phone (_____) _____

Birthdate _____ Social Security # _____

Dental Information

What is the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

Do you have dry mouth? _____If yes is when is it worse? Morning Day Night

- ❑ Do your gums bleed?
- ❑ Are your teeth sensitive to hot, cold or sweets?
- ❑ Do you get food wedged between your teeth?
- ❑ Do you have any bumps or swellings in your mouth?
- ❑ Do you have an unpleasant taste in you mouth?

If yes, please explain: _____

The following questions relate to headaches caused by the way your teeth come together and the position of your joint. Please check all that are applicable:

- ❑ Clicking or popping sound in jaw
- ❑ Wake up with headaches
- ❑ Drifting or loose teeth
- ❑ Clenching or grinding teeth
- ❑ Headaches anytime during day
- ❑ Ringing, pain or stuffiness in ear

Medical History and Information

Do you have or have you ever had?

- ❑ Arthritis
- ❑ Asthma
- ❑ Auto-immune Disorders
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Cortisone/ Steroid therapy
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Excessive Bleeding when cut
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other _____

Are you allergic to?

- ❑ Aspirin
- ❑ Codeine
- ❑ Penicillin
- ❑ Other _____

Are you currently

- ❑ Yes ❑ No

I _____

_____

What medications are you currently taking? _____

Are you taking aspirin or any other blood thinners (warfarin, Coumadin)? _____

Female Patients: Are you pregnant?

Do you take birth control pills?

- ❑ Yes ❑ No

_____

- ❑ Do you take Vitamins or Supplements? _____

Insurance

Primary Carrier

Subscriber Name _____ SS or ID # _____ Date Of Birth _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____ Do you have any other insurance coverage? _____

Insurance Authorization Statement

I understand that I am responsible for all costs and dental treatment. I hereby authorize this Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature: _____ Date _____

Treatment Authorization

Before treatment is rendered, adequate radiographs of the teeth and mouth must be taken. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. I agree to give at least 24 hours notice of cancellation or incur a $25 scheduling fee.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE /LEGAL GUARDIAN _____ DATE _____

SMITH FAMILY DENTISTRY

Matthew L. Smith DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent:

Name: _____
Mailing Address: _____
Telephone: _____ Email: _____
Patient Number: _____ Social Security Number _____

Section B: 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.
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 on Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: (928) 428-1617 **Fax:** (928) 428-0268 **E-Mail:** info.smithfamilydentistry@gmail.com

Address: 1475 South 20th Ave. Safford, AZ 85546

Right to Revoke: You will have the right to revoke the Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the 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.

SIGNATURE:

I _____, have had full opportunity to read and consider the contents of this Consent form and your 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 health care operations.

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: _____

SMITH FAMILY DENTISTRY
Matthew L. Smith DDS
OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience, we accept cash, Visa, MasterCard, Discover, personal check, money order, or registered check.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility.

As a courtesy we will be glad to file your claim for you if you bring your dental insurance wallet card and all required employer information.

You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.

We reserve the right to charge and collect fees for broken appointments – appointments that are cancelled or broken without 48-hours advance notice. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Returned Check Fee of $35.00 will be added to your account balance and is collectible.

Payment plans and financial arrangements can be entered into for comprehensive dental treatment prior to commencing treatment. Pre-payment and split payments are considered on a case by case basis.

I have read and understand this financial policy.

SIGNATURE _____

PRINTED NAME_____DATE _____

SMITH FAMILY DENTISTRY
Matthew L. Smith, DDS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communications barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement.
___ Other (Please Specify)