Patient Information

Name_________________________I prefer to be called:________________________Today's date:_________________

___Male___ Female Birthdate____/____/____ Social Security #______________________

Address____City____________________State_____Zipcode________

Tel # (Cell/Home)_________________Tel Work #________________EXT_________Email_______________________

Other family members seen at this office:____________________________Referred by___________________________

Person to contact in case of emergency: __________________Relationship:_______________Tel #_______________

Person Responsible for Account if Other Than Yourself ________________________________

Name:_________________ Relationship:______________ Birthdate:__________ Social Security #________________

Tel # (cell) ________________ Tel # (home)___________________

Primary Dental Insurance

Insurance:______________________________________Tel#___________________________ID#__________________

Address________________________________CITY______________________STATE_______________ZIP________

Subscriber: O Same as above O Other:

Name_____________________________________ Birthdate____/____/____ Social Security #________________

Secondary Dental Insurance

Insurance:______________________________________Tel#___________________________ID#__________________

Address________________________________CITY______________________STATE_______________ZIP________

Subscriber: O Same as above O Other:

Name_____________________________________ Birthdate____/____/____ Social Security #________________

TODAYS DATE_______________

Patient Name:________________________________ **D.O.B:**____/____/____ Sex: _____**Male or** _____**Female**

Parent/Guardian :__________________________

Dental History

Last Dental Visit:____________Reason for today's Visit________________ O Cleaning O New Patient O Emergency

Any unusual reaction to anesthetic? Y / N Explain____

Any fears or concerns about dental treatment?____

Please check any of the following conditions that apply :

- o **Clicking or popping TMJ/joint**
- o **Pain in TMJ/facial muscles**
- o **Grinding/clenching habit**
- o **Bad breath**
- o **Bleeding gums**
- o **Periodontal treatment**
- o **Loose teeth or broken fillings**
- o **Sensitivity to hot/cold**
- o **Sensitivity to sweets**
- o **Sensitivity when biting**
- o **Food collection between teeth**
- o **Sores or growths in your mouth**
- o **Swelling in mouth/neck**
- o **Previous injury to mouth/jaw**
- o **Previous surgery in mouth**

Medical History

Physician:__________________________ Tel #__________________ Date of last physical exam:_______________________

Has there been any change in patient's general health within the past year? Y / N If yes, what condition is being treated?

____

Has patient had a serious illness, operation or been hospitalized in the past 5 years? Y / N If yes, what was the illness or problem?

____

Please list all ***medications*** patient is taking as well as over the counter medications, herbal remedies, vitamins:

____

____

Medical History (Continued)

Does patient use controlled substances? Y / N Tobacco? Y / N Alcoholic beverages? Y / N

Have you been asked to **Premedicate** before seeing a dentist by your Doctor? Y / N

JOINT REPLACEMENT. Have you had a joint replacement? (hip,knee,elbow,finger) Y / N When?________________________________

Is patient ***allergic*** to medications (specify) ____**Latex allergy**? Y / N

(Women) Is patient pregnant? Y / N Nursing? Y / N

Does patient have a history of the following?

- **Artificial heart valve**
- **Previous infective endocarditis**
- **Damaged heart valves**
- **Damaged valve in transplanted heart**
- **Congenital heart disease**
- **Heart murmur**
- **Cardiovascular disease**
- **Pacemaker**

- **Mitral valve prolapse**
- **Rheumatic fever**
- **Angina**
- **Congestive heart failure**
- **Heart attack**
- **Stroke**
- **High blood pressure**
- **High cholesterol**
- **Kidney problems**
- **Thyroid problems**
- **Diabetes Type 1 or 2**

- **Bleeding Problems**
- **Anemia**
- **Blood transfusion**
- **Hemophilia**
- **Autoimmune disease**
- **AIDS/HIV**
- **Arthritis**
- **Osteoporosis**
- **Bronchitis**
- **Emphysema**
- **Pneumonia**

- **Sinus trouble**
- **Asthma**
- **Cancer**
- **Chemotherapy**
- **Radiation therapy**
- **Epilepsy**
- **Ulcers**
- **Glaucoma**
- **G.E. Reflux**
- **Hepatitis**

- **Mental health disorder**
- **Learning Disability**
- **Autism**
- **ADD/ADHD**
- **Hearing Loss**
- **Snoring**
- **Obstructive Sleep Apnea**
- **Fainting**

Are there any other conditions not covered in this form?____

Patient/Parent/Guardian signature: ______________________________Doctor's signature:____________________________

Personal Health Information Disclosure Agreement for VERDE SMILES

I,_____________________do hereby grant permission for Verde Smiles to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

____

____

Information to be disclosed (please check):

- ❏ **Appointment dates and times**
- ❏ **Treatment plans and referrals**
- ❏ **Financial and billing information**
- ❏ **Any other pertinent dental health information related to treatment at this office.**
- ❏ **None of the above**

I understand that this permission will remain in effect unless a written cancellation has been provided to VERDE SMILES

______________________________	______________________
Patient Signature	**DATE**
______________________________	______________________
Witness Signature	**DATE**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name:________________________________ Date of Birth:_________________

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.

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.

SIGNATURES

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 healthcare operations.

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

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: ____

Office Policies

Thank you for choosing our office to provide your dental care. We appreciate the trust you have placed in us, and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our OFFICE POLICIES. If you have any questions, please ask at the front desk.

1.VERIFYING INSURANCE

As a courtesy to you, we will verify your insurance for eligibility benefits prior to your new patient appointment. Insurance companies do not guarantee payment based on the information they provide us. You are ultimately responsible for knowing any regulations or restrictions of your insurance (waiting periods before work can be performed, benefits already used during the year, etc), as insurance is a contract between you and them, not our office. Any treatment not covered by your insurance is ultimately your responsibility.

2.PAYMENT

Payment is due at the time of service. Additionally, if you have an outstanding balance following an insurance payment, you will be expected to pay that amount as well.

3.CHANGES IN CONTACT INFORMATION

Changes in contact information (address, phone number, email) should be kept current with our office.

4.PAYMENT PLANS

Our office offers Third Party financing and In-House financing to assist you in paying for treatment. A written contract will be drawn out prior to beginning treatment, and any defaults on payment may result in additional fees being charged to your account balance.

5.BALANCES

If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. Failure to submit payment or make payment arrangements by the indicated due date may result in your account being turned over to a collection agency. **If your account balance is transferred to a collection agency, a COLLECTION FEE of 40% of your REMAINING BALANCE will be added to your account balance**. Balances must be paid in full prior to further treatment being performed.

6.RETURNED CHECKS

A $40 fee will be charged to your account for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification. Once a check has been returned, this office will no longer accept personal checks for payment. Cash, money order, or credit card will be allowed.

7.CANCELLATIONS/ FAILED APPOINTMENTS:

In order to accommodate other patients, we request 48-hours notice if you need to reschedule an appointment. If 24-hours notice is not given, or if you "no-show" an appointment a $75 fee will be applied to your account. You will not be allowed to schedule any more appointments for yourself or for family members until the fee has been paid in full. If you or your family members repeatedly no-show or reschedule without proper notice,it may be grounds for dismissal from the office.

COPY OF XRAYS / RECORDS:

In order to obtain a CD copy of your records or have them sent to another office a $40 fee must be paid. If you request a certified copy of records an additional $20 fee will be added.

Please sign below to acknowledge that you understand and accept our office policies:

Name Date