The Art of Smile

Welcome To The Art Of Smile Dental!

Thank you for taking the time to complete the following forms. If you have any questions or require assistance, please ask us and we will be happy to help.

PERSONAL INFORMATION

Name _____
Last First MI (Preferred)

Title: _____ Gender: ❑ M ❑ F Family Status: ❑ Married: ❑ Single ❑ Divorced ❑ Widowed ❑ Minor
Mr./ Mrs./Ms./etc,

College student status (if dependent over 19) ❑Full Time ❑ Part Time

Birth Date: _____ SS#_____ Previous Visit: _____

Email Address _____ Best way to contact you: ❑ Home ❑ Cell ❑ Work

Phone: _____
Home Cell Work Ext.

Address _____

City_____ State _____ Zip _____

Occupation: _____ Name of Employer: _____

How did you hear about us? ❑ Personal referral ❑ Postcard ❑ Internet ❑ Other: _____

Whom may we thank for referring you to our office? _____

Whom should we notify in an emergency? _____
Name Phone Relationship to the patient

Responsible Party:
(This only needs to be filled out if insurance subscriber is other than patient or if patient is under 18.)

The following is for : ❑ the patient's spouse ❑ the person responsible for payment ❑ neither-not applicable

Name_____
Last First MI (Preferred)

PRIMARY DENTAL INSURANCE POLICY

Name of the Insured: _____ Insured SS #: _____
Last First MI

Insured's Birth Date: _____ ID # _____ Group #: _____

Insured's Address_____

City_____ State _____ Zip _____

Name of Employer: _____

Employer's Address: _____

City_____ State _____ Zip _____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: _____

Insurance Address: _____

City_____ State _____ Zip _____

SECONDARY DENTAL INSURANCE POLICY

Name of the Insured: _____ Insured SS #: _____
Last First MI

Insured's Birth Date: _____ ID # _____ Group #: _____

Insured's Address_____

City_____ State _____ Zip _____

Name of Employer: _____

Employer's Address: _____

City_____ State _____ Zip _____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: _____

Insurance Address: _____

City_____ State _____ Zip _____

MEDICAL HISTORY

Name of your physician :_____ City/State: _____

Date and purpose of the most recent visit: _____

- ❑ Pre- Medication
- ❑ Allergy: Amoxicillin
- ❑ Allergy: Codeine
- ❑ Allergy: Penicillin
- ❑ Arthritis, Rheumatism
- ❑ Back Problems
- ❑ Circulatory Problems
- ❑ Chemical Dependency
- ❑ Excessive Bleeding
- ❑ Heart Disease
- ❑ Hepatitis C
- ❑ Jaw Pain
- ❑ Mental Disorders
- ❑ Psychiatric Care
- ❑ Scarlet Fever
- ❑ Swollen Feet or Ankles
- ❑ Tumors on head/neck
- ❑ AIDS/HIV
- ❑ Allergy: Aspirin
- ❑ Allergy: Iodine
- ❑ Allergy: Sulfa
- ❑ Artificial Heart Valve
- ❑ Blood Disease
- ❑ Congenital Heart Lesions
- ❑ Diabetes
- ❑ Fainting or Dizziness
- ❑ Heart Murmur
- ❑ Herpes
- ❑ Kidney Disease
- ❑ Mitral Valve Prolapse
- ❑ Radiation Treatment
- ❑ Shortness of Breath
- ❑ Thyroid Problems
- ❑ Ulcers
- ❑ Allergy: Novocaine
- ❑ Allergy: Barbiturates
- ❑ Allergy: Latex
- ❑ Allergy: Morphine
- ❑ Artificial Joints
- ❑ Cancer
- ❑ Cortisone Treatments
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Hepatitis A
- ❑ High Blood Pressure
- ❑ Liver Disease
- ❑ Nervous Disorders
- ❑ Respiratory Problems
- ❑ Sinus Problems
- ❑ Tonsillitis
- ❑ Valve Replacement
- ❑ Allergy: Levaquine
- ❑ Allergy: Citrus
- ❑ Allergy: Local Anesthetic
- ❑ Anemia
- ❑ Asthma
- ❑ Chemotherapy
- ❑ Coumadin
- ❑ Epilepsy
- ❑ Head Injuries
- ❑ Hepatitis B
- ❑ Jaundice
- ❑ Low Blood Pressure
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Venereal Disease

- ❑ Hospitalization for illness or injury
- ❑ Subject to frequent headaches
- ❑ Taking birth control pills
- ❑ Presently being treated for any illness
- ❑ Current or previous smoker
- ❑ Pregnant
- ❑ Fen–Phen type weight control meds
- ❑ Contact lenses wearer
- ❑ Nursing

If any conditions or alerts above need further clarifications, please describe:

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain:

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

Please list all the medications taken in the last two years and the correlating diagnosis:

_____

_____

_____

DENTAL HISTORY

Name of Previous Dentist:_____ City/State: _____

How long have you been a patient: _____ Reason for leaving: _____

Reason for today's visit / Immediate concern: _____

- ❑ Bad breath
- ❑ Chewing on one side
- ❑ Fingernail biting
- ❑ Jaw pain and tiredness
- ❑ Mouth pain or bruising
- ❑ Sensitivity to heat
- ❑ Reaction to local anesthetic
- ❑ Bleeding gums
- ❑ Smoking
- ❑ Food stuck between teeth
- ❑ Lip or cheek biting
- ❑ Pain around the ear
- ❑ Sensitivity to sweets
- ❑ Trouble getting numb
- ❑ Blisters on lips or mouth
- ❑ Clicking or popping jaw
- ❑ Teeth clenching or grinding
- ❑ Loose or broken teeth
- ❑ Periodontal treatment
- ❑ Sensitivity when biting
- ❑ Past treatment complications
- ❑ Burning sensation on tongue
- ❑ Dry mouth
- ❑ Swollen or tender gums
- ❑ Mouth breathing
- ❑ Sensitivity to cold
- ❑ Sores/ growths in the mouth

Are you pleased with your smile? _____ Today's dentistry allows us to enhance your smile quickly and easily.

How would you like your smile to look? ❑ Whiter ❑ Straighter ❑ More even ❑ Close spaces ❑ Longer teeth ❑ Shorter teeth

❑ Replace missing teeth ❑ Change gum line ❑Other. Please explain: _____

Is there a special event or occasion coming up? _____

When would you like to start? _____

What would you like to start with? _____

All information I have provided is correct to the best of my knowledge.

Signature_____ Date _____

BENEFIT ASSIGNMENT AND RELEASE

☐ By checking this box,

I authorize my insurance company to pay The Art of Smile Dental all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize The Art of Smile Dental to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance

Patient , Parent, Guardian or Personal Representative Name _____ Signature _____ Date _____

FNANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* I agree to let this office run a credit report. [ ] Yes [ ] No If no, then all fees are due at time of service.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

CONSENT TO TREATMENT

You, the patient, have the right to accept or reject dental treatment recommendation by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally. Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

- Pain, swelling and discomfort after treatment;
- Infection in need of medication, follow-up procedures or other treatment;
- Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste;
- Damage to adjacent teeth, restoration or gums;
- Possible deterioration of your condition which may result in tooth loss;
- The need for replacement of restorations, implants or other appliances in the future;
- An altered bite in need of adjustment;
- Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist;
- A root tip, bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop;
- Jaw fracture;
- If upper teeth are treated, there is a chance of sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment;
- Allergic reaction to anesthetic or medication;
- Need for follow-up care and treatment, including surgery.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary. The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please discuss with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking, antibiotics. This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above.

Please discuss the potential benefits, risks and complications of recommended treatment with your dentist.
Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient , Parent, Guardian or Personal Representative Name _____ Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

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OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, unless you specifically instruct us to do otherwise.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, messages left with family members or coworkers, or letters).

PATIENT RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosure made prior to April14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature_____ Date_____