Let's Smile DENTAL

| Patient Information | | | | | | Date: | |
|---|---|---|---|---|---|---|---|
| First Name | | | Last Name | | | | |
| Middle Initial | | Nickname: | | | Gender | M F Other | |
| Birthdate | | | Age | | | | |
| Marital Status (circle one) | Single Married Separated Divorced Widowed | | | | | | |
| Home Address | | | | | | | |
| City | | State | | Zip Code | | | |
| Home Phone Number | | Cell Phone Number | | Work Phone Number | | | |
| Email Address | | | | | | | |
| SSN | | Employer | | | | | |
| Hobbies/Activities | | Names of other family members seen at Let's Smile | | | | | |

| Parent/Guardian Information (If Patient is under 18 years of age) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Primary Provider's Full Name | | | | Relationship to child | | | |
| Home Phone Number | | Cell Phone Number | | Work Phone Number | | | |
| Email Address | | | | Will this person be the financially responsible provider? | ☐ | | |
| Will this person be the provider responsible for setting up appointments? | ☐ | Home Address (if different) | | | | | |
| City | | State | | Zip Code | | | |
| SSN | | Employer | | | | | |
| Secondary Provider's Full Name | | | | Relationship to Child | | | |
| Home Phone Number | | Cell Phone Number | | Work Phone Number | | | |
| Email Address | | | | Will this person be the financially responsible provider? | ☐ | | |
| Will this person be the provider responsible for setting up appointments? | ☐ | Home Address (If Different) | | | | | |
| City | | State | | City | | | |
| SSN | | Employer | | | | | |

| Dentist Information | | | | | |
|---|---|---|---|---|---|
| Patient's Dentist | | | | | |
| Office Address | | | | | |
| City | | State | | Zip Code | |
| Last Seen Date | | Next Appointment | | | |
| Name of other specialists being seen | | City of Practice | | | |
| Reason | | | | | |
| Who/what referred you to Let's Smile Dental? | | | | | |
| Referred By | | | | | |

| Medical Insurance | |
|---|---|
| Policy Holder's Full Name | |
| Insurance Company | |

## Medical History (Please Check All That Applies)

**Now or in the past, has the patient had:**

- ☐ Birth defects or hereditary problems?
- ☐ Bone fractures or major injuries?
- ☐ Injuries to the face, head, or neck?
- ☐ Arthritis or joint problems?
- ☐ Cancer, a tumor, radiation or chemotherapy?
- ☐ Endocrine or thyroid problems?
- ☐ Diabetes or low sugar?
- ☐ Kidney problems?
- ☐ Immune system problems?
- ☐ History of osteoporosis
- ☐ Sexually Transmitted Infections?
- ☐ AIDS or HIV positive?
- ☐ Hepatitis, jaundice, or other liver problems?
- ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ Seizures, fainting spells, neurologic problems?
- ☐ Mental health disturbance or depression?
- ☐ History of an eating disorder?
- ☐ Frequent headaches or migraines?
- ☐ High or low blood pressure?
- ☐ Excessive bleeding or bruising? Anemia?
- ☐ Chest pain, shortness of breath, tire easily or swollen ankles?
- ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ Angina, arteriosclerosis, stroke, or heart attack
- ☐ Skin disorder (other than common acne)?
- ☐ Vision, hearing, or speech problems?
- ☐ Frequent ear infections, colds, throat infections?
- ☐ Asthma, sinus problems, hay fever?
- ☐ Tonsil or adenoid condition?
- ☐ Consistent mouth breathing?
- ☐ Has the patient taken intravenous bisphosphonates such as Zometa (zolendromi acid), Adredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐ Has the patient ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate) or Skelid (tilidronate) for bone disorders?

**Please describe any additional medical history we should be aware of:**

**Has the patient ever had allergies or reactions to any of the following:**

- ☐ Local anesthetics (Novocain, lidocaine, xylocaine)
- ☐ Latex
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Penicillin
- ☐ Other antibiotics
- ☐ Metals
- ☐ Acrylics
- ☐ Plant Pollen
- ☐ Animals
- ☐ Foods
- ☐ Other Substances: _____

**Please list any medications/Supplements the patient is taking (also list those taken within the last 3 months):**

## The Patient's Physician (Children Only)

| | | | |
|---|---|---|---|
| Patient's Physician | | City, State | |
| Date of last visit | | Reason | |
| Date of most recent physical exam | | Any concerns? | |

## Other Physicians/Health Care Providers Being Seen?

| | | | |
|---|---|---|---|
| Name | | Reason | |
| Name | | Reason | |

## Dental Insurance

| | | | | | |
|---|---|---|---|---|---|
| Primary Policy Holder's Full Name | | | | Date of Birth | |
| SSN | | Relationship to Patient | | | |
| Address | | | | | |
| City | | State | | Zip Code | |
| Employer | | Address | | | |
| City | | State | | Zip Code | |
| Insurance Policy | | Group # | | ID # | |
| Does this policy have orthodontic benefits? | | | | | |
| (If Applicable) Secondary Holder's Full Name | | | | Date of Birth | |
| SSN | | Relationship to Patient | | | |
| Address | | | | | |
| City | | State | | Zip Code | |
| Employer | | Address | | | |
| City | | State | | Zip Code | |
| Insurance Policy | | Group # | | ID # | |
| Does this policy have orthodontic benefits? | | | | | |

## Dental History (Please Check All That Applies)

**Now or in the past, has the patient had:**

- ☐ Erupting teeth unusually early or late?
- ☐ Primary (baby) teeth removed that were not loose
- ☐ Permanent or extra (supernumerary) teeth removed
- ☐ Supernumerary (extra) or congenitally missing teeth
- ☐ Chipped or injured primary or permanent teeth?
- ☐ Any sensitive or sore teeth?
- ☐ Jaw fractures, cysts, infections?
- ☐ Any teeth treated with root canals or pulpotomies?
- ☐ Frequent oral habits (finger sucking, chewing pens, etc)?
- ☐ Frequent Canker Sores or cold sores?
- ☐ History of speech problems or speech therapy?
- ☐ Mouth breathing habit or snoring at night?
- ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ Tooth grinding or clenching?
- ☐ Clicking or locking in Jaw Joints?
- ☐ Soreness in jaw muscles or face muscles?
- ☐ Treated for TMJ or TMD problems?
- ☐ Any broken or missing fillings?
- ☐ Any serious trouble associated with previous dental treatment?
- ☐ Been diagnosed with gum disease or pyorrhea?
- ☐ Other:

## Doctor's Notes (DOCTOR'S USE ONLY)

NOTES:

_____ _____

**Doctor's Signature** **Date**

## Release and Waiver

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA

*I authorize release of any information regarding the patient dental treatment to my dental and/or medical insurance company.*

Patient/Guardian Signature_____ Date_____

*I have read the above questions and understand them. I will not hold the dentist, orthodontist, oral surgeon or any member of his/her staff responsible for any errors of omissions that I have made in the completion of this form. I will notify the dentist, orthodontist, or oral surgeon of any changes in the patient medical or dental health. I also authorize the dental staff to perform the necessary dental services the patient may need.*

Patient/Guardian Signature_____ Date_____

# Parental Consent Form

***Needed only for Patients Under 18 Years Old***

*Note: At Let's Smile Dental, we value and appreciate our patients as well as their parents and guardians. To keep our workflow as efficient and as safe as possible, we have updated our policies with regards to who may bring a patient for an appointment:*

- *If a child under the age of 18 presents by themselves without the parent or legal guardian, we will have to reschedule their appointment. Phone calls will not be accepted as confirmation of parental supervision.*
- *If a parent or guardian is unable to be present at the time of the appointment, you may have an individual that is 18 years or older accompany your child if they are listed below, OR have filled out the parental consent form in-practice.*
- *For new patient appointments, the legal parent or guardian must be present at the first appointment.*

Child(ren) Name(s):

_____ _____

_____ _____

Authorized Caregiver's Name: _____

Relationship to child(ren): _____

Caregiver's Phone number: _____

By signing below, I give permission for the above name caregiver to be authorized to accompany the above-named child(ren) for their orthodontic appointments and subsequent recall visits. Treatment to be performed includes routine orthodontic services outlined during the initial consultation appointment. The initial patient registration package, all medical history/dental history must be filled out by parent or legal guardian. This consent shall be effective from date of signature until revoked by parent or legal guardian.

**Signature of Parent/Guardian** **Date**

_____ _____

**Printed Name**

_____

# Let's Smile Dental HIPAA Form

**Consent Agreement**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement as it relates to the use and disclosure of individually identifiable health information (IIHI), but many practices will continue to use the Consent Agreement for other purposes. Though it is not necessary to have your consent to allow us to use or disclose your IIHI to others who will treat or you support in providing you quality health care services, it is important to have you consent to use or disclose your IIHI to health care plans to insure accurate and timely payment for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI through our Privacy Notice We may already have a consent agreement from you. Please refer to our Privacy Notice for full explanation of how this office will protect your individually identifiable health information (IIHI).

The following is a statement that allows us the necessary latitude to work within the new requirements.

I, _____ (Responsible Party/Patient Name Printed) have been presented with a Privacy Notice explaining my rights regarding my individually identifiable health information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment. payment, or other health care operations (TPO)_ Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

**Privacy Notice**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*My signature indicates that I have received a copy or have been asked about receiving a copy of the privacy notice.*

## Thank you,

Patient or Responsible Party Name:_____

Signature of Patient or Responsible Party:_____

Patient Name:_____

Date:_____

**HIPPA NOTICE OF PRIVACY ACT**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

## PLEASE REVIEW CAREFULLY

How we may use and disclose your health information

1. **Treatment:** We may use and disclose Health Information for your treatment and to provide you with treatment related health care services.
2. **Payment:** We may use and disclose Health Information so that we or others may bill and receive payment from you, insurance company, or a third party for the treatments and services you received.
3. **Health Care Operations**: We may use and disclose Health information for health care operation purposes. These uses and disclosures are necessary to mak sure that all our patients receive quality care and to operate and manage our office.
4. **Appointment reminders, treatment alternatives, and health related benefits and services**: We may use and disclose Health information to remind you of your appointment.
5. **Individuals involved in your care or payment of your care**: We may share Health Information with a person involved in your medical care or payment for your care. Such as family, your close friends, or guardian.
6. **Research:** under certain circumstance, we may use and disclose your Health information for research purposes.

**SPECIAL SITUATIONS**

**As Required by Law:** we may disclose Health Information as required by international, federal, state, or local law.
**To Avert a Serious Threat to Health or Safety:** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the safety and health of public or another person.
**Business Associates:** We may use and disclose Health Information to our business associates who function on our behalf or provide us with services such as billing.
**Organ and Tissue Donation**: If you are an organ donor, we may use or release Health Information to organization that handles organ procurement, banking or transportation.
**Military and Veterans:** If you are a member of the armed forces, we may release Health Information as required by military command authorities.
**Workers' Compensation**: We may release health information for workers' compensation or similar programs.
**Public Health Risks:** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report birth and deaths; report child abuse or neglect; report reactions to medication or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or condition; and report to appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
**Health Oversight Activities:** We may disclose Health Information to health oversight agency for activities authorized by law.
**Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, we may disclose Health Information in response to administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
**Law Enforcement:** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
**Coroners, Medical Examiners, and Funeral Directors**: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.
**National Security and Intelligence Activities:** We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
**Protective Services for the President and Others:** We may disclose Health Information to authorize federal officials so they may provide protection to the president, other authorized persons or foreign heads of state, or to conduct special investigations.
**Inmates or Individuals in Custody:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care. 2) to protect your health and safety or the health and safety of others, or 3) for the safety and security of the correctional institution.
**Your Rights**
You have the following rights regarding Health Information we have about you:
**Right to Inspect and Copy:** You have the right to inspect and copy Health Information that may be used to make decision about your care or payment of your care. This includes medical and billing records. To inspect and copy this Health Information, you must make your request, in writing, to Let's Smile Dental.
**Right to Amend:** If you feel that Health Information, we have is incorrect, or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Let's Smile Dental.
**Right to an Accounting of Disclosures:** You have the right to request a list of certain disclosures w made of Health Information for purposes other than treatment, payment, and health care operations for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Yes Braces.
**Right to Request Restrictions:** You have the right to request a restriction of limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in you care or the payment for your care, such as a family member or friend. To request a restriction, you must make your request, in writing, to Let's Smile Dental. We are not required to agree to your request. If we agree, we will comply with you request unless the information is needed to provide you with emergency treatment.
**Right to Request Confidential Communication:** You have the right to request that we communicate with you about the medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to Let's Smile Dental. Your request must specify how or where you wish to be contacted. We will accommodate reasonable request.

Let's Smile DENTAL

**New-Patient Policies**

## Financial Policy

Payment is due the date services are rendered. Our office submits claims to your insurance as a courtesy. Any portion of the insurance balance that is left unpaid by the insurance company will default to the responsible party. Our office will contact you should this occur. After 90 days all accounts that are not paid in full may be sent to a third-party collection agency. Any accounts turned over to collections will be assessed a collection fee of 30%.

_____ _____

**Signature of Responsible Party** **Date**

_____

**Responsible Party Name (Print)**

_____

**SSN**

_____

**Date of Birth**

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## Cancellation Policy

I acknowledge that I will be responsible for the fees that follow for a broken or no-show appointment if the 24-hour prior cancellation notice is not given.

### Fees

- $50 Pediatric/Orthodontic Routine Appointment
- $75 Restorative
- $100 Oral Sedation
- $200 General Anesthesia

_____

**Patient's Name**

_____ _____

**Patient or Guardian Signature (if under 18 years old)** **Date**

## Photo Release Form

I hereby grant permission to **Let's Smile, PC** to use my/my child's photograph and/or video in any marketing, advertising or teaching materials used to market or advertise the orthodontic practice, including use on their web site and/or social media sites.

I acknowledge the practice's right to crop or otherwise treat the photograph or video at their discretion. I also acknowledge that the practice may choose not to use my photograph and/or video now but may do so at their discretion later.

I also understand that once my image is posted on the web site, the image can be downloaded by any computer user, which is beyond the control of the practice. I will hold the practice and any affiliated offices harmless from any such use or download.

I hereby freely and voluntarily consent to the use of my photograph and/or video.

_____

**Patient Signature (or Parent/Guardian Signature if under the age of 18)**

_____

**Printed Name**

_____

**Date**

---

I hereby **DO NOT** grant permission to **Let's Smile, PC** to use my/my child's photograph and/or video in any marketing, advertising or teaching materials used to market or advertise the orthodontic practice, including use on their web site and/or social media sites.

_____

**Patient Signature (or Parent/Guardian Signature if under the age of 18)**

_____

**Printed Name**

_____

**Date**