SMILES
FOR LIFE
DENTAL GROUP

NOTICE OF PRIVACY POLICIES

Health Insurance Portability Accountability Act (HIPAA), 1996
http://www.hhs.gov/ocr/hipaa/finalreg.html

Name: _____ Phone: _____

Address: _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

YOUR RIGHTS
You have the right to have access and/or copies of your PHI records at any time. You have the right to request additional restrictions on your PHI, and we will do so unless legally bound otherwise. You have the right to refuse to sign the consent form, or to rescind your consent.

_____
Signature

FOR OFFICE USE:
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 (Specify) _____

SMILES FOR LIFE DENTAL GROUP

ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

SS #: _____

Birthdate: _____ Age: ____ ☐ Male ☐ Female ☐ Gender Neutral

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

Cell #: _____

E-mail Address: _____

How do you prefer to be contacted? ☐ E-Mail ☐ Phone ☐ Text

Employer: _____

Occupation: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

How did you find out about us? ☐ Friend ☐ Google ☐ ZocDoc ☐ Yelp ☐ Facebook ☐ Other

Whom may we Thank for referring you? _____

INSURANCE COVERAGE

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

SS #: _____ Birthdate: _____

Person Responsible for Account: _____

Cell: _____ Employer: _____

Billing Address: _____

Relation: _____ SS #: _____

EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: _____ Cell #: _____

CONTINUED ON BACK

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

- ☐ Abnormal Bleeding
- ☐ Alcohol / Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes / Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+ / AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic / Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease / Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline

Please list any other drugs/materials that you are allergic to:

_____

_____

DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? a day do you brush?

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ Date _____

Signature

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

_____

Signature Date

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

INTERNAL USE

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

Treatment Consent

Pooja Goel, DDS
Smiles for Life Dental Group

1. **Work to be done**
   I understand that I am having the following work done: Fillings
   _____
   _____
   (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 when necessary.
   (Initials _____)

4. **Removal of teeth**
   Alternatives of 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 under 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. **Crowns, 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 infection or loss and that is 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 minor _____ Date _____

Smiles for Life Dental Group

POLICIES

Please read the following policies and sign at the bottom to indicate that you have read and understand our office financial policies.

Insurance

In order for us to maintain a high level of service to you, we provide the courtesy of submitting your insurance claim on your behalf. Policy coverage, changes, and follow-up on unpaid claims is your responsibility.

In order to provide this service to you, we must have complete insurance information and confirmation of your coverage. If we have not received payment from your insurance company within 60 days of billing, the balance becomes your responsibility.

Insurance coverage is a contract between you or your employer and your insurance company. We have no control over this relationship. We can only estimate what your insurance will pay since each insurance company has their specific limitations.

Payment Options

Our office accepts cash, check, and credit card.

If you need to make long term payments, we can offer financing through Care Credit. You must qualify to use this financing option. We reserve the right to charge a $35.00 fee on all returned checks.

Delinquent Accounts

For all accounts over 60 days with patient amounts due, there will be a $10 billing fee or a finance charge of 1.5% per month, whichever is more.

After 120 days all accounts that are not paid in full, may be sent to a third party collection agency.

Should this account become past due, you agree to pay any reasonable additional fees, including any and all collection agency, legal fees and/or court costs, necessary to collect this amount.

Cancellation Policy

Due to the fact that we are reserving time on our schedule for your appointment, we ask that you provide 24 hours notice for any appointments that you may need to change. All changes in your scheduled appointment must be handled during our normal business hours.

Communication

Our office sends email and text message confirmations to your phone. By signing below you agree to receive text messages. You may opt out of text messages afterward. The doctor may also text or call you from her personal phone for appointments.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have reviewed the privacy policies of Smiles for Life Dental Group.

Name (please print)

X_____ _____

Signature Date

For Office Use Only:

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

____ *Individual refused to sign*

____ *Communication barriers prohibited obtaining acknowledgement*

____ *An emergency situation prevented us from obtaining acknowledgement*

____ *Other (please specify)* _____