Caring Smiles
DENTAL

Today's Date_____

Patient Name _____ Preferred Name _____

Mailing Address _____ City _____State _____ Zip _____

Home Phone _____ Work_____ Cell _____ Text Messages Yes____ No___

E-mail address_____ Employer _____

DOB _____ SSN (if using insurance) _____

Person Responsible for Account _____Spouse Name _____

Who was your last dentist? _____ Last time you had dental x-rays? _____

How did you hear about us? (circle one) Yelp Google Flyer Newspaper Other_____

	Primary Insurance	Secondary Insurance
Name of Subscriber	_____	_____
Carrier	_____	_____
Phone #	_____	_____
Address	_____	_____
Member ID #	_____	_____
Group #	_____	_____
Employer	_____	_____
Date of Birth of Subscriber	_____	_____
Social Security # of Subscriber	_____	_____

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Pediatric Health History

Patient Name _____ Birthdate _____ Weight _____lbs

Dentist Name _____ Appt Date _____

Parent Name _____ Address_____

Home phone _____ Mother/Cell_____ Father/Cell _____

Does your child have, or have they ever had, any of the following? (If yes, check the box)

□ Asthma, Reactive Airway, Wheezing, Breathing
□ Pneumonia, Bronchitis, Chronic Cough
□ Croup (barking cough), Stridor
□ Respiratory Problems (Tuberculosis, Cystic Fibrosis)
□ Sleep Apnea (stop breathing while asleep) I Nighttime Snoring
□ Breathing through mouth due to nasal congestion
□ Shortness of breath/fatigue/dizziness when running
□ Fainting spells or Blackouts
□ Heart Murmur
□ Congenital Heart Defect, Damaged or Abnormal Heart Valve
□ Irregular Heart Beat, Palpitations, Arrhythmia
□ Heart Disease, High or Low Blood Pressure
□ Rheumatic Fever /Scarlet Fever
□ Bleeding, Nose Bleeding, Easy Bruising, Clotting Problems
□ Anemia (Including Sickle Cell Anemia) □ Blood Transfusions
□ Organ transplant/ Bleeding disorder

□ Head & Neck injury or trauma (Brain or Spinal Injury)
□ Complications at birth
□ Previous general anesthesia or surgery
□ Problems during or after anesthesia
□ Family relatives having problems during or after anesthesia
□ Cancer, Tumor, Chemotherapy, Radiation therapy
□ Thyroid Disease, Adrenal gland problems, Hormone Therapy
□ Hiatal Hernia, Heartburn, Acid Reflux, Indigestion
□ Stomach/intestinal problems (ulcers/bleeding, other)
□ Swallowing Difficulties, Aspiration or Choking episodes
□ Genetic Disorder, Congenital Abnormalities, Syndrome
□ Seizure I Epilepsy/ Convulsions (other brain disorders)
□ Kidney Disease, Bladder Disorders
□ Liver Disease (Jaundice I Hepatitis, other)
□ Diabetes, Nutritional Disorders
□ ADD or ADHD, Autism (circle one or more)
□ Muscle Disease (Muscular Dystrophy, others)
□ HIV/AIDS

□ Autoimmune disease/suppressed immune system.

1. Any cold, cough, fever, flu or sore throat within the last 4 weeks? (please circle all that apply) □Yes □ No
2. Past hospitalizations/surgeries or emergency room visit? Reason? □Yes □ No
3. Was the child born premature? How many weeks at birth? □Yes □ No
4. Does your child have ANY disease, condition or problem not mentioned so far? □Yes □ No
5. Does the patient take any medication regularly and/or as needed (including over the counter?) □Yes □ No
6. Are there any behavioral/emotional/cultural/spiritual concerns that we need to be aware of? □Yes □ No

List all allergies: (latex, soy, egg, sulfa, aspirin, Ibuprofen, codeine, antibiotics, local anesthetics etc.)
Other: _____ What happens? □ Rash/hives □ Breathing problems/wheezing □ Swelling □ Itching

Name:_____ Signature: _____
(Parent or Legal Guardian)

Reviewed by dentist:

Signature: _____ Date:_____

Financial Policy

Dental treatment is an excellent investment to an individual's overall health. Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we will assist to help maximize your insurance benefits and make any remaining balance easily affordable. We will be sensitive to your financial circumstances and do everything possible to help you achieve dental health.

Insurance

_____ (Initial) We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Your insurance policy is a contract between you and your insurance company, we often receive limited information from your insurance company regarding your benefits. We will assist you with your benefit eligibility before treatment to help you estimate your costs and maximize your insurance. We request that any copayments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental policy. *The fees for treatment are your responsibility whether your insurance company pays or not.* We request that a credit card be left on file which will be charged if there is any remaining balance after your insurance company pays.

Payment Plans

_____ (Initial) Patients have the option to place 40% down on the agreed treatment plan at a 15% APR, afterwhich, monthly payments will be collected for up to four months maximum. The entire amount of services rendered must be paid in full within four months of the service date. Payment Plans must be agreed upon prior to the service date.

Forms of Payment

_____ (Initial) **Payment is due at the time services are rendered unless prior arrangements have been made.** We accept the following forms of payment: Cash, Cashier Checks, Visa, MasterCard, Discover and American Express. In addition, we partner with CareCredit, a patient payment program offering a full range of No Interest and Extended Payment Plans for treatment fees. We do not accept checks, we apologize for any inconvenience this may cause.

Collections

_____ (Initial) Any account that has not received payment after 90 days will be handed over to a

collection agency that will pursue the responsible party for reimbursement. All past due accounts submitted for collection will be subject to collection fees and/or attorney's fees. We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most financial misunderstandings can be managed with a phone call.

Minor Patients

_____ (Initial) The adult accompanying a minor who signs this financial policy is responsible for full payment at the time of service.

Deposit Policy

_____ (Initial) Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for appointments over 2 hours, we require a deposit fee to make your appointment.

Rescheduling Policy

_____ (Initial) Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of 24 hours notice so that we may make every effort to accommodate other clients. If proper notice is not received, a fee of $25.00 *may* be charged for every hour of allotted time cancelled.

I have read and agree to the Financial Policy and the Cancellation Policy of Caring Smiles Dental.

Print: _____

Sign: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 April 14, 2003, 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 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, but only if you agree that we may do so.

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, or letters.)

PATIENT RIGHTS

Access: You have the right to look at 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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 and certain other activities, for the last 6 years, but not before April 14, 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.

Restrictions: 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 that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have

received a copy of this office's Notice of Privacy Practices.

Sign:_____

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

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please specify)

_____

Caring Smiles
DENTAL

Photo Release

At Caring Smiles Dental we always take our patient's oral health and privacy to heart. Taking an active part in helping a person redeem or maintain his or her smile for a lifetime, is our goal.

We are interested in sharing patient's success stories and/or transformations through education, research, website and other means of communication. Please read through the consent below and let us know if you are in favor, or not, of authorizing our doctors and staff to use photographs or video of you and your bright smile.

I, _____ (Patient), authorize Caring Smiles Dental Care, to take photographs and/or videos of my face, jaw and teeth before, during and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites, social media, printed materials, and patient education
- I do not expect compensation, financial or otherwise, for the use of these photographs/videos

_____ Check here if you will allow photographs and/or videos to be used for the above purposes.

_____ Check here if you prefer photographs and/or videos be kept confidential and only used for in-office reference use.

Signature (Patient) _____
Date _____

Thank You