NEW PATIENT FORM

Basic Information

Patient First Name: | Patient Last Name: | Preferred Name: | Gender: | Preferred pronouns: | DOB:

Marital status: | SSN #: | Employer: | Occupation:

Referral source: | Referred by:

Contact Information

Mobile phone: | Home phone: | Email:

Address Information

Street address: | City: | State: | ZIP:

Emergency Contact

Full Name: | Phone number: | Relation:

Work Information

Street address: | City: | State: | ZIP:

Patient's signature:

Sign

HEALTH HISTORY

Summary

Medical Conditions | Allergies | Medications

General Health Information

Are you currently under the care of a physician?

- ○ Yes
- ○ No

If yes,

Physician phone number: | Date of last physical exam:

Are you presently being treated for any injury or illness? | If yes:

- ○ Yes
- ○ No

Have you ever been hospitalized for an injury or illness?

- ○ Yes
- ○ No

If yes:

Are you pregnant or planning to become pregnant?

- ○ Yes
- ○ No

If yes:

Are you currently breastfeeding?

- ○ Yes
- ○ No

Are you required to pre-med with antibiotics before dental treatment?

- ○ Yes
- ○ No

If yes:

Do you use alcohol?

- ○ Yes
- ○ No

If yes:

Do you use or have you ever used tobacco?

- ○ Yes
- ○ No

If yes:

Have you ever had an allergic reaction?

- ○ Yes
- ○ No

If yes:

Medical Conditions

Do you have a history or are currently being treated for any Digestive conditions?

Do you have a history or are currently being treated for any Heart or Circulatory conditions?

Do you have a history or are currently being treated for any Neurological conditions?

Do you have a history or are currently being treated for any Lung or Breathing conditions?

Do you have a history or are currently being treated for any Autoimmune conditions?

- ☐ Anemia
- ☐ Artificial Joint
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Head or neck injuries
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Other
- ☐ Radiation therapy
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or Growths

- ☐ Osteopenia
- ☐ Measles / chicken pox?
- ☐ If Diabetes, Type I or
- ☐ Type II diabetes?

Please mention if there are any other medical conditions we should be aware of.

Medications

Please check all medications you are currently taking

- ☐ Are you taking any pain medications?
- ☐ Are you taking any Antidepressants or Anxiety medications?
- ☐ Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?
- ☐ Are you taking any Allergy or Asthma medications?
- ☐ Are you taking any Antibiotics?
- ☐ Are you currently taking any other medications or dietary supplements?

If any other medications:

Patient's signature:

Sign

Doctor's signature:

Sign

DENTAL HISTORY

General Information

Who was your previous Dentist and how long were you a patient there?

Date of your last dental exam:

Date of your last cleaning:

Do you have any immediate concerns you'd like us to address?

Office Relationship

What do you value most in your dental visits?

Is there anything you prefer during your visits to make you more comfortable during your time with us?

On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?

	1	2	3	4	5
.	○	○	○	○	○

Personal History

Please answer the following questions

Are you concerned about the appearance of your teeth?

Are you interested in improving your smile?

Have you had any cavities within the past 2 years?

Are any teeth currently sensitive to biting, sweets, hot, or cold?

Do you avoid or have difficulty chewing or biting heavily any hard foods?

Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth?

Do you clench your teeth in the daytime?

Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?

Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?

Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?

Have you ever noticed a consistently unpleasant taste or odor in your mouth?

Dental Structural History

Please answer the following questions

Do your gums bleed when brushing or flossing?

Is brushing or flossing typically painful?

Have you ever experienced or been told you have gum recession?

Have you ever been treated for or been told you have gum disease?

Have you had any teeth removed for braces or otherwise?

Do you know of any missing teeth or teeth that have never developed?

Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?"

Are your teeth becoming more crowded, overlapped, or "crooked?"

Are your teeth developing spaces?

Do you frequently get food caught between any teeth?

Have you noticed your teeth becoming shorter, thinner, or flatter over the years?

Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)

Is it often difficult to open wide?

Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together?

Patient's signature:

Sign

DENTAL INSURANCE INFORMATION - Primary Insurance Information

Do you have a dental insurance?

○ Yes

○ No

Would you like to upload insurance card photo?

○ Yes

○ No

If Yes, Upload - FRONT:

No File Uploaded

BACK:

No File Uploaded

Patient's relationship to the Insurance Holder:

Policy Holder's Name:

Policy Holder's Date of Birth:

Policy Holder's SSN:

Policy Holder's Address (City, State, Zip):

Policy Holder's Phone Number:

Policy Holder's Employer:

Dental Insurance Company:

ID Number:

Group Number:

Phone number on the back of your insurance card:

Address on the back of your insurance card:

Secondary Insurance Information

Do you have a secondary dental insurance?

- ○ Yes
- ○ No

That's all! If you would like to add secondary insurance, you need to provide primary insurance first.

Would you like to upload insurance card photo?

○ Yes

○ No

If Yes, Upload - FRONT:

No File Uploaded

BACK:

No File Uploaded

Patient's relationship to the Insurance Holder:

Policy Holder's Name:

Policy Holder's Date of Birth:

Policy Holder's SSN:

Policy Holder's Address (City, State, Zip):

Policy Holder's Phone Number:

Policy Holder's Employer:

Dental Insurance Company:

ID Number:

Group Number:

Phone number on the back of your insurance card:

Address on the back of your insurance card:

PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you. 2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 502 N Coalter St, Staunton, VA 24401: 3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice. 4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. 5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense. 6. If this office initiated this authorization, you must receive a copy of the signed authorization. 7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records. 8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature:

Sign

FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are grateful for the opportunity to help you smile. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, we will file the claim for your insurance. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. We strive to make sure your financial agreement is clear and any payment arrangements are made prior to scheduling your treatment. If you have any questions concerning the the fees for your treatment, it is your responsibility to have these answered prior to treatment to minimize any confusion. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist. FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. UNPAID BALANCE: Any unpaid balance over 90 days will be subject to be sent to our collection agency. The patient will be responsible for payment of collection agency fees, attorney fees and any court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS: We understand "life happens" and sometimes there is a need to reschedule your appointment. We request a 24 hour notice so that there is time to schedule another patient that has been waiting. If there are multiple cancellations without notice, you will be asked to pay for your appointment at the time of making the appointment to reserve your time slot.

☐ I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature:

Sign

COMMUNICATION CONSENTS - EMAIL CONSENT FORM

PURPOSE:

This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Smiles for Life - Staunton offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Smiles for Life - Staunton will use reasonable means to protect the security and confidentiality of email information sent and received. However, Smiles for Life - Staunton cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Smiles for Life - Staunton and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Smiles for Life - Staunton.

Patient's signature:

Sign

TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE:

This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Smiles for Life - Staunton, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Smiles for Life - Staunton will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Smiles for Life - Staunton cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Smiles for Life - Staunton and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Smiles for Life - Staunton.

Patient's signature:

Sign

HIPAA - RELEASE OF INFORMATION AUTHORIZATION FORM

HIPAA - Release of Information Authorization Form

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), must first be authorized. Authorization includes the signature of the individual authorizing the release of their information. Information will not be available to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

☐ I want to provide the authorization

The above information may be released and/or received by

The following is an authorization allowing Smiles for Life - Staunton to release information to whomever you designate. Smiles for Life - Staunton is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to:

Relation of person/organization that the office may release information to:

☐ I want to add a second person/organization

Name of person/organization that the office may release my information to:

☐ I want to add a third person/organization

Name of person/organization that the office may release my information to:

Patient's signature:

Sign

ID/LICENSE UPDATE

Please upload your ID and License picture:

No File Uploaded

Upload

No File Uploaded

Signature:

Sign