TO THE PATIENT: PLEASE COMPLETELY FILL OUT SECTIONS 1, 2 & 3, SIGN AND DATE WHERE INDICATED.

Patient Information

SECTION 1

Date:_____

Name:_____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female
Last First M

Birth Date: ____/____/____ SS# _____-_____-_____ Drivers License Number:_____

Address: _____
Street Apt # City State Zip

E-Mail Address_____ Phone – Home:_____

Phone – Work: _____ Ext. _____ Time to Call: _____ Cell: _____

Place of Employment _____ Occupation/Position_____

If Full time Student, School Name:_____ Grade_____

Medical Insurance Company:_____ ID#_____ Group # _____

Dental Insurance Company:_____ ID#_____ Group # _____

Has any member of your family been treated in our office? ☐ Yes ☐ No Local #_____

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

Insured Information

IF THE PRIMARY SUBSCRIBER IS SOMEONE OTHER THEN YOURSELF

☐ ***Father*** ☐ ***Husband***

_____
Last First M

_____
Street City State Zip

_____
Home # Work #

_____
Birth Date (Mo/Day/Year) SS#

_____
Employer Drivers License #

_____
Dental Insurance Co. Group #

☐ ***Mother*** ☐ ***Wife***

_____
Last First M

_____
Street City State Zip

_____
Home # Work #

_____
Birth Date (Mo/Day/Year) SS#

_____
Employer Drivers License #

_____
Dental Insurance Co. Group #

Emergency Information

XXXXXXXXXXXXXXXXXXXX Family/Household Contact

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Responsible Party

Responsible party currently is a patient of record at this office ☐ Yes ☐ No

Method of Payment:
Patients will be expected to pay for services when treatment is rendered.
Visa/MasterCard are accepted.
I wish to discuss interest free financing with Care Credit

If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Professional care is provided ***to you, our patient, and not to an insurance company***. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and in handling insurance questions from our office on your behalf. However, insurance balances 60 days and over are ***due in full from the patient***.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I realize a responsible adult (parent or guardian) must remain in the office while treating a minor.

In connection with dental services which I am receiving, I consent that photographs, audio, and/or video recording may be taken of me, for the explicit use of dental research, education, training or science, provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name. I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or other showing of the photographs/video tape regardless of whether such use of said photographs/video tape is commercial, institutional or private sponsorship, and irrespective of whether any fee or charge is received.

Initials: _____ Date: _____

☐ Adult Patient ☐ Father ☐ Husband ☐ Mother ☐ Wife ☐ Guardian

PLEASE PRINT YOUR NAME

SECTION 2

Medical History

	Yes	No
Are your under a physician's care now? Why? Who?	☐	☐
Date of last physical exam		
Have you ever been hospitalized or had an operation? Describe	☐	☐
Have you ever had a serious injury to your head or neck? Describe	☐	☐
Are you taking any medications, pills or drugs? (Include illegal/recreational drugs) What?	☐	☐
Are you on a special diet? Describe	☐	☐
Are you allergic to any medications or substances? Please check box for allergic reaction below	☐	☐

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other

Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Describe

Do you have or have you ever had any of the following:
(*If yes to any of the * starred conditions, please call prior to your appointment...premedicatons may be required)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Radiation Therapy	☐	☐	Thyroid Disease	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problems)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐
Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐
Scarlet Fever*	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problems	☐	☐	Diabetes	☐	☐	Artificial Joints*	☐	☐
Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐
Heart Surgery*	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS*	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A & C (Infectious)	☐	☐	Herpes (Cold Sore)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B (Serum)	☐	☐	Drug Addiction/Use	☐	☐
Alcohol Use/Abuse	☐	☐	Fever Blisters	☐	☐	Hepatitis C	☐	☐	Genital Herpes	☐	☐
Depression	☐	☐	ADD/ADHD	☐	☐	Stroke	☐	☐	Snoring / Sleep Apnea	☐	☐
						Seizure	☐	☐			

Have you ever had any other serious illness not checked above? Describe	☐	☐
Do you wish to talk to the dentist privately about any problem?	☐	☐

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that I am taking.

In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you can get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST: ☐ ***I DO WANT A COPY OF 'NOTICE'*** ☐ ***I DO NOT WANT A COPY OF 'NOTICE'***

SIGN: _____ _____ _____ _____ _____ _____ Date: _____

☐ *Adult Patient* ☐ *Father* ☐ *Husband* ☐ *Mother* ☐ *Wife* ☐ *Guardian*

Reviewed by Doctor _____ Date _____ BP _____

History review and significant findings: _____

Medical History Update

Date	Comments	Signature

SECTION 3

Dental History (Patient To Fill Out Completely)

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Date of your last dental visit_____ For what?_____

	Yes	No
Date of your last dental cleaning _____		
Do you have a specific dental problem? Describe_____	☐	☐
What kind of dental procedures have you had done in the past?_____	☐	☐
Do you have any sensitive teeth?_____	☐	☐
Have you ever had a toothache or a fractured tooth? _____	☐	☐
Have you ever had periodontal problems?_____	☐	☐
Do you like your smile? Why? _____	☐	☐
Does food catch between your teeth or do you have areas that are difficult to floss? _____	☐	☐
Does loss of teeth tend to run in your family?_____	☐	☐
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____	☐	☐
Have you ever had Orthodontics (Braces)? _____	☐	☐
Have your past experiences in a dental office always been positive? _____	☐	☐
Do you smoke or chew tobacco? Any sores or growths in your mouth? Describe_____	☐	☐
Name of previous dentist (Optional)_____	☐	☐
Why did you leave your last dentist? _____	☐	☐
Have you noticed spots or stains on your teeth that concern you? _____	☐	☐
Anything else that concerns you about the appearance of your teeth? _____	☐	☐

If you could change anything about your smile, what would you change? _____

_____

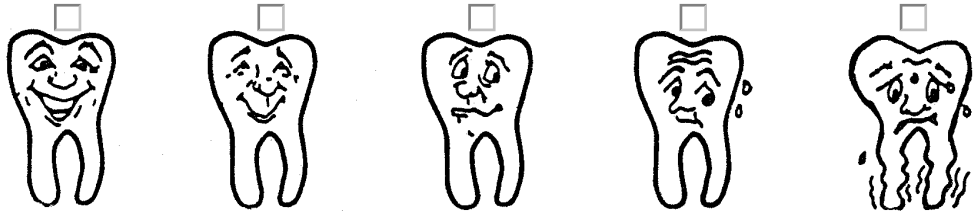
Do you have a denture or partial denture? ☐ No ☐ Yes How old are they? _____How do you like them? _____

_____

Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment? _____ ☐ ☐

Check Your Level of Bravery: Don't Worry, We Cater To Cowards

☐ ☐ ☐ ☐ ☐



SECTION 4

Initial Clinical Exam (I.C.E.)

Date:_____ Patient Name:_____

Blood Pressure: _____ : _____

Stains: ☐No ☐Lt ☐Mod ☐Hvy

Calculus: ☐No ☐Lt ☐Mod ☐Hvy

Plaque: ☐No ☐Lt ☐Mod ☐Hvy

Bleeding: ☐No ☐Lt ☐Mod ☐Hvy

TMJ: ☐Asymptomatic ☐Symptoms: _____

Homecare: Brushing: ____ x/day Floss:_____ x/week

Perio Diag: ☐Normal ☐Gingivitis ☐Early Perio ☐Mod Perio ☐Adv Perio ☐Maint

Instructions: ☐Brush ☐Floss ☐Perio Aid ☐Other:_____

Ortho: Occlusal Type: ☐CLI ☐CLII ☐CL III

Soft Tissue Screening

Cancer Exam: ☐Normal ☐Lesion: Describe _____

See dental history for smoking history

	Normal	*Abnormal*	
Lips	☐	☐	_____
Mucosa	☐	☐	_____
Palate	☐	☐	_____
Tongue	☐	☐	_____
Floor	☐	☐	_____
Glands	☐	☐	_____
Pharynx	☐	☐	_____

Upper Right	Upper Anterior	Upper Left
Lower Right	Lower Anterior	Lower Left

Maximum Pocket Depth Per Sextant in mm

Recall: _____Months Doctor's Signature: Reviewed by: _____

SBD Dental Financial Policy & Consent for Services

Welcome to our office. We are dedicated to providing you with the very best dental care and services, as a result, your understanding of our financial policy is an essential element of your care and treatment. To assist you, we have the following financial policy. Please read it thoroughly. If you have any questions, please feel free to discuss them with our office staff.

Please initial each line item confirming you have read it.

_____ **Dental Insurance Policy-** Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. 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. You, the financially responsible party, agree that should your insurance company fail to pay any portion of the claim(s) due to frequency limitations, exclusions,maximums, deductibles, age limitations, waiting periods, eligibility, termination or any other reason not listed you are 100% financially responsible. Benefits and eligibility are verified upon request from the patient. It is patient responsibility to provide us with accurate insurance benefit details including a copy of the insurance card if applicable, subscriber ID, birthdates, and any other information pertaining to acquiring insurance benefits. Insurance carriers only provide a Summary of dental benefits and not a guarantee of payment. This office cannot render services on the assumption that our charges will be paid by your dental insurance. If something is not covered on your insurance plan, it does not mean it was not necessary, it simply means it may NOT be a covered benefit on your particular dental plan. For benefit details about your plan please call your dental insurance company directly for the most accurate information. I understand that Dental Insurance carriers cannot and do not diagnose treatment. The goal of dental insurance is to pay for the least expensive option for dental treatment not the best option for your health. Insurance carriers may downgrade their payments for procedures.

Pre-Authorizations are NOT a guarantee of payment.

_____**Payment/Patient Portion is due when services are rendered unless a prior payment arrangement has been made:** For your convenience, we accept Visa, MasterCard, Discover, and American Express credit cards; we also accept cash and check payments. Outside financing is available through Care Credit with interest free payment options (Care credit cannot be combined with Promotional offers).

_____ **Deposit Policy-** Due to the extensive amount of time our staff and doctors devote to preparing for your appointment **We do require a deposit to reserve your time with the doctor for major dental work** .In the event you cancel, reschedule or no show with **less** than 2 business days notice, you will forfeit your deposit and be required to pay a new deposit upon rescheduling.

_____ **Reschedule/ Change in Schedule Policy**- 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 48 hours-notice so that we may make every effort to accommodate other clients. If proper notice is not received, a fee of $50.00 will be charged for every hour of allotted time cancelled

_____ **In the event your account balance is 30 days past due, a $20 per month late fee will be charged to your account and will be sent to collections after 90 days**. A $50 fee for cancelled/returned checks will also be added to your account.

_____**There is a $45 fee to copy/e-mail patient records, unless we are copying them for a specialist referral we have arranged. They require a release form signed and may take 5-10 business days to process.**

_____ **Minors-** Separated or divorced parents of minors, who are responsible for one half of the cost of a childs/childrens dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. If it is necessary, we are happy to hold a credit/debit number from the non-custodial parent on file.

Consent for Services & Standard of Care

* Standard of care is a legal concept that a dentist must meet and is the basic practices of highly regarded dentists who have comparable education and knowledge, who practice in similar disciplines and those who practice in a comparable area. The standard simply reflects that which is minimally required, meaning that anything less would be considered negligent.

Standard of care for our office is as follows:

- **The doctor and hygienist recommend regular cleanings a minimum of 1 time every 6 months, regardless of insurance coverage.**
- **Fluoride Varnish to protect my teeth from cavities- min. 2 times a year and may not be covered by insurance**
- **Periodontal maintenance cleanings 1 time every 3-4 months with irrigation which may not be covered by insurance**
- **Doctor/Dentist requires x-rays be taken in order to be able to diagnose accurately.**
- **Dental X-rays are a very important diagnostic tool- We require at a minimum Full mouth x-rays are taken every 3 years, check-up x-rays are taken annually. We will accept digital x-rays from another office as long as they are less than 3 mo. old from the date taken**
- **Emergency/Limited Exam/Dental Treatment x-rays are taken as needed.**

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor. I give consent to the doctor or designated staffs use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for purpose of carrying out my treatment, payment and health care operations to make a thorough diagnosis of myself or my dependents dental needs. I understand that this office does I grant my permission to you or your assignee, to telephone, text, e-mail me at home or at my work to discuss matters related to my dental health as well as to receive appointment reminders and confirmations and I am .

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

I, (please print) _____, have read and understand the Financial Policy & Consent for Services for Smiles by Design San Diego.

Signed: _____ 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 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 June 22, 2009, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may 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. We will post a copy of our notice in our office and on our website www.dentalworks.com. The effective date of the Notice is provided above.

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 the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may 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 another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

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, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

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

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. 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 uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: 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, and 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 fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 5875 Landerbrook Drive, Suite 250, Mayfield Heights, OH 44124.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 5875 Landerbrook Drive, Suite 250, Mayfield Heights, OH 44124. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 5875 Landerbrook Drive, Suite 250, Mayfield Heights, OH 44124.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, 5875 Landerbrook Drive, Suite 250, Mayfield Heights, OH 44124. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, 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, 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 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.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
5875 Landerbrook Drive, Suite 250
Mayfield Heights, OH 44124
Telephone: (440) 684-6940