smiles
ON STATE STREET

DATE:

PATIENT INFORMATION

Name: **I prefer to be called:**

Address: **City:** **State:** **Zip:**

Phone: Home: **Cell:** **Work:**

Date of Birth: **Social Security Number:** **Drivers License:**

Employer: **Occupation:**

Circle appropriate answer: **Minor** **Single** **Married** **Widowed** **Separated** **Divorced**

May we text you regarding upcoming appointments? Please circle one: **Yes / No**

Email:

By providing your email address you agree to receive appointment reminders, and/or any information requested by you via email and you understand that there might be some level of risk involved that third parties might be able to read unencrypted emails. _____ (initial)

Who may we thank for referring you *or* how did you hear about us?

Person to contact in case of an emergency? **Phone:**

RESPONSIBLE PARTY

Relationship to Patient *(circle one)*: **Self** **Spouse** **Parent** **Other:**

Name: **Date of Birth:**

Address *(if different from patient)* **:**

City: **State:** **Zip:** **Phone:**

Social Security: **Employer:**

INSURANCE INFORMATION

Primary Insurance

Name of Insured: **DOB:** **Relationship to Patient:**

Member ID or SSN: **Name of Employer:**

Insurance Company: **Group Number:**

Insurance Phone: **Insurance Address:**

Secondary Insurance

Name of Insured: **DOB:** **Relationship to Patient:**

Member ID or SSN: **Name of Employer:**

Insurance Company: **Group Number:**

Insurance Phone: **Insurance Address:**

Welcome!

We know you have many options for your dental care and we are so happy you chose us! We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Please take a moment to read over some important information regarding our policies and please let us know if you have any questions.

1. **Payment:** Payment is due at the time services are rendered unless a financial agreement is completed prior to performing any treatment with our practice. Treatment Plans, along with cost, will be presented to all patients (or patient's parent/guardian). Any changes to treatment will be added and reviewed on a new Treatment Plan. We accept all major credit cards, checks, cash, and CareCredit (third party lender). INITIAL:_____

2. **Patients with Insurance:** The PATIENT (or patient's parent/guardian) is responsible for the ESTIMATED non-covered portions, procedures, and/or deductibles at the time of service. **While we are in network with most insurances, and we do our best to inform you of your estimated costs, you are ultimately responsible for all charges incurred at Smiles on State Street regardless of insurance coverage.** We must emphasize that as your dental care provider, our relationship is with, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and/or the insurance company. We are NOT a party to this contract. If payment from your insurance company is not received within 60 days of service, you may be expected to pay the balance in full. **INITIAL:_____**

3. **I authorize** the release of necessary information to my dental insurance to process my dental benefits claims. I hereby authorize payment from my dental insurance directly to **Dr. Mortensen at Smiles on State Street.** **INITIAL:_____**

4. **Past Due Accounts:** If your account becomes 90 days past due, we may send your account to a collection agency. **INITIAL:_____**

5. **Returned Checks:** There is a $30 fee for non-sufficient funds or returned checks. **INITIAL:_____**

6. **Missed Appointments:** We reserve time with the doctor and our hygienist for you and your dental health. We ask the you give us a 24-hour notice if you are unable to make it to your appointment. When a patient misses an appointment, it can impact the entire office and prevent other patients from getting their preferred appointment time. Habitually missed appointments will incur a fee of $50 and/or will require a deposit to reserve a new appointment. **INITIAL:** _____

7. **Whitening:** We offer custom whitening trays and two free tubes of whitening gel to our new patients, along with one tube of bleach every six months. This offer will be effective so long as you remain a patient with Smiles on State Street and you maintain your regular six-month check- ups. **A fee of $100 will be charged to replace any lost trays. INITIAL:_____**

8. **I authorize** Dr. Mortensen to take radiographs (xrays), study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I understand the use of anesthetic agents and certain treatments embody some risk. In good faith the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed in an informed fashion. **INITIAL:_____**

9. **The information I have given today is correct to the best of my knowledge. INITIAL: _____**

By signing below, you agree to all the terms and conditions contained herein and the agreement will be in effect.

Patient Name:

Responsible Party:

Signature: **Date:**

HEALTH HISTORY

Todays Date:

Patient Name : **Date of Birth:**

GETTING TO KNOW YOU:

What is most important to you about your dentist or dental practice?
Have you ever had to pre-medicate or been told to for dental treatment due to heart conditions, open heart surgery, or artificial joints, etc.?
Have you ever had periodontal treatment (deep cleaning, root planning, periodontal surgery?
Women Only: Are you or could you be pregnant? Are you nursing?

WHAT CONCERNS DO YOU CURRENTLY HAVE WITH YOUR ORAL HEALTH OR SMILE? *(CHECK ALL THAT APPLY)*

_ Jaw joint pain	_ Clenching/grinding of teeth	_ Discolored teeth	_ Missing or loose teeth
_ Old fillings / Crowns	_ Tooth much gum tissue when I smile	_ Other:	

DO YOU HAVE ANY ALLERGIES TO THE FOLLOWING? *(PLEASE CHECK ALL THAT APPLY)*

_None _ Local Anesthetic _ Asprin _ Sulfa _ Latex _ Penicillin _ Codeine _ Metal _ Other:

Have you had or do you have any of the following? *(Please check all the apply)*

_ anemia	_ arthritis	_ artificial heart valve	_ artificial joint
_ asthma	_ back problems	_ cancer, tumor	_ chemotherapy
_ circulatory problems	_ cortisone treatment	_ congenital heart disorder	
_cough up blood	_ persistent cough	_ diabetes	_ epilepsy, seizures
_ fainting, dizziness	_ glaucoma	_ headaches	_ heart attack
_ heart murmur	_ hepatitis, Type____	_ herpes	_ high blood pressure
_ immune disorder	_ jaundice	_ kidney disease	_ liver disease
_ mitral valve prolapse	_ pacemaker	_ prolonged bleeding disorder	
_ radiation treatment	_ respiratory disease	_ Rheumatic Fever	_ scarlet fever
_ shortness of breath	_ sinus trouble	_ skin rash	_ stroke
_ feet/ankle swelling	_ tonsillitis	_ lung disease	_ ulcer
_ tobacco	_ venereal disease	_ recreational drugs	
_ AIDS/HIV	_ Psychiatric Care	_ Chemical Dependency	
_ major surgeries:		_ Fen-Phen; if yes, when?	
_ taking/have taken medication for bone density, such as any bisphosphonate (Actonel, Fosomax)			

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Furthermore, I will not hold my dentist, or any other member of the dental team responsible for any errors or omissions that I have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent or guardian) **Date** **Signature of Dentist** **Date**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:	**Date:**
Patient Signature:	
Patient's Representative's Signature:	
Relationship to Patient:	

For Office Use Only
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights due to the following reason:
○ **The patient refused to sign**
○ **Emergency situation**
○ **Communication barriers**
○ **Other**