smartmouth
family dental

Welcome to Smart Mouth Family Dental. Please take a few minutes to fill out the form. If you have any questions, we are glad to assist you.

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Gender: M / F Date of Birth:_____ SSN:_____ Driver's License #:_____ Married: Y / N

Street Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Home Phone:_____ Cell Phone:_____

Employer Name:_____ Employer Phone:_____

Emergency Contact:_____ Phone:_____

How did you hear about Smart Mouth Family Dental?:_____

RESPONSIBLE PARTY

If the patient is under 18 years old, please complete the following:

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____ Gender: M / F Married: Y / N SSN:_____ Driver's License #:_____

Email Address:_____ Home Phone:_____ Cell Phone:_____

INSURANCE POLICY 1

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name:_____ Subscriber ID #:_____

Insurance Company:_____ Phone:_____

Employer:_____ Group Name:_____ Group #:_____

FINANCIAL AGREEMENT

For my convenience, this office may release my information to my insurance and receive payment directly from them. If sent to collections, I agree to pay all related fees and court costs. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. Treatment plans may change and I will be responsible for the work actually done. I understand that all fees are payable at the time of treatment.

Signature:_____ Date:_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State:_____

List any medications you are now taking:

[ ] None
_____
_____
_____
_____

Check medications or drugs you are allergic to:

[ ] None
[ ] Aspirin
[ ] Codeine/Other Narcotics
[ ] Erythromycin
[ ] Latex Rubber
[ ] Local Anesthetics
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Other:_____

Check any medication conditions you may have:

[ ] None
[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Anemia/Leukemia
[ ] Anorexia/Bulimia
[ ] Arthritis
[ ] Asthma/Hay Fever
[ ] Blood Clotting Problems
[ ] Blood Transfusion
[ ] Bronchitis
[ ] Cancer/Tumor or Growth
[ ] Cardiac Pacemaker
[ ] Chest Pain upon Exertion
[ ] Damaged Heart Valve
[ ] Other:_____
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting Spells/Seizures
[ ] Fever Blisters/Herpes
[ ] Frequent Headaches
[ ] Frequent Dry Mouth
[ ] Gall Bladder Trouble
[ ] Heart Attack/Stroke
[ ] Heart Disease/Angina
[ ] Heart Murmur
[ ] Hepatitis/Jaundice
[ ] High Blood Pressure
[ ] Hives/Skin Rash
[ ] Joint Replacement
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Problems
[ ] Mitral Valve Prolapse
[ ] Persistent Diarrhea
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Sexually Transmitted Disease
[ ] Sinus Trouble
[ ] Stomach Ulcers
[ ] Thyroid Problems
[ ] Tuberculosis

Are you taking, or have you taken, bisphosphonates (e.g., Fosomax) for osteoporosis? Y / N
Tobacco use? Y / N If so, what kind and how much?_____
Unusual reaction to dental injections?_____
Women: Are you pregnant? Y / N Are you taking birth control pills? Y / N

DENTAL HEALTH

Reason for today's visit:_____ Are you in pain? Y / N
Date of last dental visit:_____
Do you have your wisdom teeth? Y / N Are you missing any teeth?:_____
How happy are you with your smile? Choose 1-10: Not Happy 1 2 3 4 5 6 7 8 9 10 Very Happy
Do your gums bleed? Y / N

By signing below, I certify that all of the above information is true to the best of my knowledge.

Signature:_____ Date:_____

Bienvenido a Smart Mouth. Por favor, tómese unos minutos para llenar el formulario. Si usted tiene alguna pregunta, estamos encantados de ayudarle.

INFORMACIÓN DEL PACIENTE

Apellido:_____ Primer Nombre:_____ Inicial:_____

Sexo: M / F Fecha de Nacimiento:_____ SSN:_____ Número de Licencia:_____ Casado: S / N

Domicilio:_____ Ciudad:_____ Estado:_____ Código Postal:_____

Correo Electrónico:_____ Teléfono de Su Casa:_____ Celular:_____

Empleador:_____ Teléfono de Su Trabajo:_____

Contacto en Caso de Emergencia:_____ Número de Teléfono:_____

¿Cómo escuchó de nosotros?:_____

INFORMACIÓN DE LA PERSONA RESPONSABLE

(Si usted es la persona responsable, no llene esta sección.)

Apellido:_____ Primer Nombre:_____ Inicial:_____

Sexo: M / F Fecha de Nacimiento:_____ SSN:_____ Número de Licencia:_____

Correo Electrónico:_____ Teléfono de su casa:_____ Celular:_____

INFORMACIÓN DEL SEGURO PRIMARIO

Relación del paciente con el asegurado (circule): [ ] Yo mismo [ ] Esposa(a) [ ] Hijo(a) Otro:_____

Nombre del Asegurado:_____ # del ID de Suscriptor:_____

Compañia de Seguros:_____ Teléfono de la Compañia de Seguros:_____

Empleador:_____ Nombre del Grupo:_____ Numero del Grupo:_____

RESPONSIBILIDAD FINANCIERA

Para mi conveniencia, esta oficina puede divulgar mi información a mi seguro y recibir el pago directamente de ellos. Si se envía a las colecciones, estoy de acuerdo en pagar todas las tasas y costas judiciales. Cada esfuerzo será hecho para que me ayude con mi seguro, pero si no le pagan como se esperaba, todavía seré responsable. Los planes de tratamiento pueden cambiar y yo seré responsable por el trabajo efectivamente realizado. Entiendo que todos los gastos se pagan en el momento del tratamiento.

Firma del Paciente:_____ Fecha:_____

HISTORIA DE SALUD

Nombre de su Médico:_____ Ciudad/Estado:_____

Enumere los medicamentos que está tomando:

[ ] None
_____
_____
_____
_____

Alergias:

[ ] Aspirina
[ ] Codeína y Narcóticos
[ ] Eritromicina
[ ] Penicilina
[ ] Productos de Látex
[ ] Anestésicos Locales
[ ] Metales
[ ] Sulfamidas
[ ] Otro:_____

¿Tiene o tenía alguna vez alguno de los siguientes?:

[ ] Ninguno
[ ] Reemplazo de Articulaciones
[ ] Enfermedades de la vejiga
[ ] Enfermedades del hígado
[ ] Presión arterial baja
[ ] Problemas de salud mental
[ ] El prolapso de la válvula mitral
[ ] La diarrea persistente
[ ] Enfermedades de la vesícula biliar
[ ] Problemas con coagulación de la sangre
[ ] Enfermedad reumática del corazón
[ ] Problemas del estómago
[ ] Enfermedad de transmisión sexual
[ ] Dolor en el pecho debido a esfuerzo
[ ] Otro:_____
[ ] Diabetes
[ ] Enfisema
[ ] Alcohol/Drogas
[ ] Anemia
[ ] Anorexia/Bulimia
[ ] Dolores de cabeza frecuentes
[ ] Asma
[ ] Fiebre reumática
[ ] Infarto
[ ] Enfermedad del corazón
[ ] Cancer
[ ] Un marcapasos
[ ] Problemas de tiroides
[ ] La urticaria / erupción en la piel
[ ] VIH/SIDA
[ ] Enfermedades de los riñones
[ ] Convulsiones
[ ] Desmayos o mareos
[ ] Herpes/ Ampollas de fiebre
[ ] Artritis
[ ] Boca seca
[ ] Soplo cardíaco
[ ] Broncitis
[ ] Sinusitis crónica
[ ] Hepatitis / La ictericia
[ ] Alta presión sanguinea
[ ] Tuberculosis
[ ] Problema válvular o reemplazo

¿Usa o ha usado medicamentos bifosfonatos (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa o Bonefos)? S / N

Usa tabaco? S / N Cantidad por día?_____

Tiene una reacción unusual a inyecciones dentales?_____

Mujeres: ¿Está embarazada? S / N ¿Está lactando? S / N ¿Toma píldoras anticonceptivas? S / N

SALUD DENTAL

¿Cuál es la razón de su visita hoy?:_____ ¿Tiene dolor? S / N

¿Cuándo fue tu última visita al dentista?:_____

¿Tiene sus muelas del juicio? S / N ¿Le faltan algunos dientes?:_____

¿Está feliz con su sonrisa? Escoja un numero de 1-10: No muy feliz 1 2 3 4 5 6 7 8 9 10 Muy feliz

¿Le sangran las encías? S / N

Mi firma a continuación certifica que he leído y completado el formulario en su totalidad. He estipulado todos los problemas médicos de los que tengo conocimiento.

Firma del paciente :_____ Fecha:_____

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review 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.

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 according to the means outlined in 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/dentist 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 a 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 prescriptions, dental 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, letters, or text messages).

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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge a fee for copies of your x-rays and of your dental record and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.
- **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.
- **Restriction**: 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. This request must be 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. This 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 received this notice on our Web site or by electronic mail (e-mail), you are also entitled to receive this notice in written form.

QUESTIONS AND CONCERNS

If you would like additional information about our privacy practices or have questions, please ask the Office Manager.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or our handling of your 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 send your concerns to Smart Mouth Family Dental's Corporate Office, Attn: HIPAA Compliance, 1127 S. Austin Ave., Denison, TX 75020. You also may submit written concerns to the U.S. Department of Health and Human Services.

We support your right to maintain 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.

Smart Mouth Family Dental

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign the Acknowledgment)

I have received/was offered a copy of this office's Notice of Privacy Practices.

Print name_____

Signature_____

Date_____

I authorize Smart Mouth Family Dental to discuss and/or release my medical information including labs and test results, diagnosis, and treatments discussed to the following individuals. Also, I authorize Smart Mouth Family Dental to discuss my account information including account balances, insurance information, statements, and payment options to the same persons.

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____