# Welcome

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.*

Patient # _____

SS#/SIN _____

Date _____

## Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

**Over Please**

# Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | ☐ | ☐ |
| If yes, please explain _____ | | |
| 3. Are you taking any medication(s) including non-prescription medicine? | ☐ | ☐ |
| If yes, what medication(s) are you taking? _____ | | |
| 4. Have you ever taken Fen-Phen/Redux? | ☐ | ☐ |
| 5. Do you use tobacco? | ☐ | ☐ |
| 6. Do you use controlled substances? | ☐ | ☐ |
| 7. Are you wearing contact lenses? | ☐ | ☐ |

9. Are you allergic to or have you had any reactions to the following?

| | Yes | No |
|---|---|---|
| Local Anesthetics (e.g. Novocain) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please list) _____ | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) | ☐ | ☐ |
| 11. Women Only: | | |
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking oral contraceptives? | ☐ | ☐ |

8. Do you have or have you had any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Easily Winded | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Angina | ☐ | ☐ | Hay Fever / Allergies | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Heart Trouble | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Stomach Troubles / Ulcers | ☐ | ☐ | Other _____ | ☐ | ☐ |

# Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| Clicking | ☐ | ☐ |
| Pain (joint, ear, side of face) | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 13. Have you had any orthodontic treatment? | ☐ | ☐ |
| 14. Do you wear dentures or partials? | ☐ | ☐ |
| If yes, date of placement _____ | | |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 16. Do you like your smile? | ☐ | ☐ |

# Authorization and Release

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____ Signature _____ Date _____

SMILES by DESIGN

*Cosmetic & Family Dentistry*

**Scott Bartlett, D.D.S.**

3140 Central Mall Drive • Port Arthur, TX 77642
**Telephone: (409) 727-2164**
**Fax: (409) 727-5222**

# Payment Options

We offer multiple payment options:

- Cash
- Check
- Care Credit
- Credit Cards (MasterCard, Visa, American Express)

Payments made in cash will receive a 5% discount on any work above $200.00. This discount only applies to cash payments. No credit cards or checks will qualify. Exclusions include Senior Citizens Discounts, Invisalign, Somnomed and Ortho Retainer.

## ****INSURANCE*****

Our office is happy to verify and file your insurance claim free of charge immediately following your appointment. We are only able to estimate what insurance will pay for certain procedures; we have no way to guarantee payment because the contract is between you and your insurance company. You are responsible for any fees the insurance denies on procedures performed in this office.

Our office IS NOT AN IN-NETWORK PROVIDER FOR ANY INSURACE COMPANY. We will file your insurance the day your procedure is completed, again after 60 days if necessary. If the claim reached 80 days past due, it will then be your responsibility to pay the outstanding balance. All necessary information will be given to you to re-file the claim if you desire.

Patient Signature: _____

Date:_____

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# Notice of Privacy Practices

***This notice describes how medical/dental information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.***

Family Dentistry respects your right to privacy and will protect your personal and health information. We will not disclose information contained in your medical records to any third party (including your family, friends, employer, attorney, etc.) without your written consent.

## How We Use Information About You

We will gather certain medical information about you and will create a record of the care provided to you. Some information may also be gathered from other medical providers caring for you. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our Privacy Practices and Policies, please contact the office manager, Ms. Kim Barnes. Your personal and identifiable health information about you may be used for the following purposes:

1. Required Disclosures-Your health information may be disclosed to the Secretary of Health and Human Services upon request, to determine our compliance with the Health Insurance Portability and Accountability Act of 1996, and to you, in accordance with your right to access and receive an accounting of disclosures.
2. For Treatment- Your health information may be used during the course of your treatment.
3. For Appointments- Information about you may be used to contact you for appointment reminders and about missed appointments.
4. For Health Care Operations- Information about you may be used for the general operation of our clinic. For example: We may have accrediting agencies or consultants who review our practices, evaluate our operations, and make suggestions on provision of quality care.)

## Release of Medical and Personal Information Without Your Consent

In some instance, we may be required by federal, state, or local law to release information without your consent. Family Dentistry is required to:

1. By law report injuries that are the result of criminal activities. (example: gunshot wounds, stabbings, etc.)
2. Report information for public health records. (example: certain communicable diseases.)
3. Report information regarding victims of abuse, neglect, or domestic violence.
4. Provide all information requested by subpoena or other order of a court or administrative hearing body, or to assist law enforcement to identify or locate a suspect, fugitive, material witness, or missing person. Disclosures for law enforcement purposes also permit disclosures about victims of crime or the death of an individual.
5. Report health information to certain governmental agencies pertaining to members of the armed forces or pertaining to prisoners.

6. Disclose health information in connection with certain health oversight activities of licensing and other health oversight agencies, authorized by law. Health oversight activities include audits, investigations, accreditation, inspections and licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of:
    a. The health care system
    b. Government benefit programs for which health information is relevant
    c. Entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards
    d. Entities subject to civil rights laws for which health information is necessary for determining compliance.
7. Release information to the coroner or medical examiner to identify a deceased person or to determine the cause of death.
8. Release information to organ procurement organizations, transplant centers, and eye or tissue banks if you are an organ donor.
9. Also share information in your medical records with other healthcare professionals when it is necessary. This exchange of information is necessary to ensure that you receive the best possible health care.

**Your Individual Rights**

You have the right to:

1. Ask for restrictions on the ways we disclose and use your health information for treatment, payment, and health care operations purposes. You may request that we limit our disclosures to persons assisting with your care. We will consider your request, but are not required to accept it.
2. Request that you receive communications containing your protected health information from us by alternative means or at alternative locations. (example: You may request that we only contact you at home or by mail.)
3. Inspect copies of your records and to obtain copies of medical, billing, and other records used to make decisions about you under certain circumstances. If you ask for copies of this information, we may charge you a fee for copying and mailing.
4. Correct the existing information or add missing information if you believe that information in your records is incorrect or incomplete. Requests to update information must be made in writing to the privacy officer. Under certain circumstances, we may deny your request.
5. Receive a list of instances when we have used or disclosed your medical information. We are not required to include in the list used and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you gave us permission to make, and disclosures before April 14, 2003, among others. If you ask for this information from us more than every twelve months, we may charge a fee.

To exercise any of your rights or to obtain more information, please contact the office manager, Ms. Kim Barnes in writing at Family Dentistry.

**Complaints and Comments**

If you have complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services at 200 Independence Ave, SW, Room 509F, HHH building, Washington D. C., 20201 or at ormail@hhs.gov. We support your right to privacy of your information and 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 Review of Notice of Privacy Practices

I have reviewed the Family Dentistry Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Authorized Representative Date

# Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

***I wish to be contacted in the following manner (check all that applies):***

**Home telephone**

- o Ok to leave message with detailed information
- o Leave message with call back number only

**Work telephone**

- o Ok to leave message with detailed information
- o Leave message with call back number only

**Written communication**

- o Ok to mail to my home address
- o Ok to mail to my work address

**Other**

- o Explain _____

_____ _____

Signature of Patient Date

_____ _____

Print Name Birth Date

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# Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of _____, 20____

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

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# Smile Reminder

We are making it more convenient for you to communicate with our practice. We will be sending appointment reminders via email and text message to your cell phone. Please provide us with your current information and have one less phone call to answer.

Cell Phone#_____

E-mail Address_____

If you are not interested in these services please sign below

_____