SmileLine DENTISTRY
THE ART & SCIENCE OF SMILES

Dental Registration

Date: _____ Cell Phone: _____ Home Phone: _____ Work Phone: _____

1. PERSONAL INFORMATION	2. RESPONSIBLE PARTY INFORMATION
Name: _____ Address: _____ City: _____ Zip: _____ Birthdate: _____ Age: _____ Social Security Number: _____ Marital Status: _____ Sex: M or F Occupation: _____ Email: _____ Referral Source: _____	Name: _____ Address: _____ City: _____ Zip: _____ Social Security Number: _____ Marital Status: _____ Sex: M or F Occupation: _____ Home Phone: _____ Cell Phone: _____ Relationship: _____

3. EMERGENCY CONTACT	4. EMPLOYER /SCHOOL
Name: _____ Address: _____ City: _____ Zip: _____ Phone: _____ Relationship: _____	Employer Name: _____ Address: _____ City: _____ Zip: _____ Phone: _____ Email: _____

5. INSURANCE INFORMATION

Subscriber Name: _____ Subscriber's Date of Birth: _____
Name of Insurance Company: _____ Relationship to patient: _____
Insurance ID/SSN: _____ Group Number: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with: _____ and assigned directly to Smile Line Dentistry all insurance benefits. If any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of signature on all insurance submissions. The above name dental office may use my health care information and may disclose such information in the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan to completed or one year from the date signed below

Signature: _____ **Date:** _____

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OUR OFFICE / FINANCIAL POLICY

Payment in full is due when services are rendered unless other arrangements have been made. We offer several options of payment for the services we provide: **Cash, Check, Visa, and MasterCard**. Since we believe that your health should not be compromised because of a lack of immediately available funds or insurance benefits, we also provide payment plans through **Care Credit**. Care Credit allows our patients, who qualify; the opportunity to spread out the cost of treatment into small monthly payments (**INTEREST FREE**). Any patients who would like to take advantage of this convenient option for payment needs simply to fill out an application. **Initials:** _____

USUAL & CUSTOMARY FEES: We are committed to providing excellent dental treatment to all of our patients. Our fees and services reflect our commitment to the quality our patients deserve and expect when visiting a dental practice, and are not guided by arbitrary determinations by the insurance companies. **Initials:** _____

INSURANCE: As a courtesy to our patients, we will bill your insurance company as our office is committed to helping you maximize your benefits. **HOWEVER, YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOUR INSURANCE COMPANY AND YOURSELF.** As a health care provider, we are not party to your agreement with your insurance. **INSURANCE POLICIES VARY AND SERVICES PROVIDED MAY NOT BE COVERED. THE BALANCE IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE PAYS OR NOT. Initials:** _____

MISSED APPOINTMENT: One of the ways we keep our fees more affordable is by avoiding missed appointments. Although we understand that occasionally our patients will need to reschedule their appointments, please notify us 24-48 hours prior to your appointment to avoid a fee of $35.00 for every half hour scheduled. It is our office policy that we will not offer you another appointment after three missed appointments. **Initials:** _____

RETURNED CHECKS: We will charge $50.00 for all returned checks. All fees incurred to collect payments will be payable by the patient. **Initials:** _____

CHILDREN UNDER 18:

We require all children under the age of 18 to be accompanied by a parent or legal guardian. During the time the patient is in the office, we request the parent/guardian stay in the office as treatment may change or questions may arise that only the parent/guardian can answer. The patient registration form must be signed by the parent or legal guardian accompanying the minor at the first appointment. That guarantor ultimately bears the legal responsibility for payment. We are unable to know the financial responsibilities of divorced parents. We will look to the adult accompanying the minor for payment.

I understand and agree that I am personally responsible for all fees, regardless of insurance coverage. I agree to pay any attorney fees, collection fees, or any cost that may occur to satisfy my financial obligation for the dental treatment provided to me and my family by Smile Line Dentistry. I hereby authorize any of the doctors to proceed with and perform the dental treatments as explained to me. I understand that dentistry is not an exact science; therefore, reputable practitioners cannot guarantee results. I understand and agree to the financial-office policy above.

*X*_____ _____

Signature of Patient or Responsible Party Date

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MEDICAL HISTORY *(Please circle each answer)*

Name: _____ **Date:** _____

Current List of Medication: _____

_____

Are you in good health?	**Y**	**N**	Do you wear pacemaker?	**Y**	**N**
Have you ever been hospitalized? If so, what was the problem?	**Y**	**N**	History of joint replacement? If so, when?	**Y**	**N**
Are you under care of M.D? Date of last medical exam: _____	**Y**	**N**	Are you allergic to: **Latex Penicillin Codeine Other medication?**		
Do you have any medical condition you think I should know?	**Y**	**N**	Local injected anesthetics?	**Y**	**N**
			Have you ever had heart surgery?	**Y**	**N**
			Have you had any serious illness?	**Y**	**N**

Physicians Name: _____ Telephone_____

Stroke	**Y**	**N**	Respiratory Disease	**Y**	**N**	Epilepsy	**Y**	**N**
Fainting Spells or Seizure	**Y**	**N**	Tuberculosis	**Y**	**N**	HIV Positive	**Y**	**N**
Hepatitis, Jaundice or liver disease	**Y**	**N**	Nervous Disorders	**Y**	**N**	Radiation treatment of any kind	**Y**	**N**
Heart Ailments / Valve Surgery	**Y**	**N**	Kidney Disease	**Y**	**N**	Prescribed FEN-PHEN	**Y**	**N**
Mitral Valve Prolapse	**Y**	**N**	Tumors/Growths/Cancer	**Y**	**N**	Bisphosphonates/ Osteoporosis	**Y**	**N**
Heart Murmur	**Y**	**N**	Rheumatic Fever	**Y**	**N**	History of smoking	**Y**	**N**
Excessive Bleeding	**Y**	**N**	Rheumatism or Arthritis	**Y**	**N**	History of drug abuse	**Y**	**N**
Blood Diseases	**Y**	**N**	Sinus Trouble	**Y**	**N**	Asthma or Hay Fever	**Y**	**N**
High blood pressure	**Y**	**N**	Head Injuries	**Y**	**N**	Allergies	**Y**	**N**
Anemia	**Y**	**N**	Stomach Ulcers	**Y**	**N**	Are you pregnant?	**Y**	**N**
Diabetes	**Y**	**N**	Venereal Disease	**Y**	**N**	Are you nursing?	**Y**	**N**

DO YOU SNORE - YES OR NO

DENTAL HISTORY

Reason for your visit today? _____			Have you ever had any complications from an Extraction If yes, explain:	**Y**	**N**
How long since you been to a dentist?			Do you grind/clench your teeth?	**Y**	**N**
How often do you floss your teeth?			Have you ever had a popping or clicking near your ear when you chew?	**Y**	**N**
How often do you brush your teeth?			Are you prone to frequent headaches?	**Y**	**N**
Have you ever been treated for Periodontal disease?	**Y**	**N**	Do you experience aching or stiffness in your face neck or shoulder?	**Y**	**N**
Do your gums bleed when you brush?	**Y**	**N**	Have you ever had orthodontic treatment	**Y**	**N**
Do you have sores, blisters or swelling on your gums, lips or cheeks?	**Y**	**N**			

IS THERE ANY ADDITIONAL MEDICAL OR DENTAL INFORMATION WE MAY NEED TO KNOW BEFORE BEGINNING TREATMENT

_____

_____

X_____ **X**_____

PATIENT / GUARDIAN'S SIGNATURE **DOCTOR'S SIGNATURE**

HEALTH HISTORY UPPDATE

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Date _____

Changes to medical history _____

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Patient Signature _____

Doctor Signature _____

Date _____

Changes to medical history _____

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Patient Signature _____

Doctor Signature _____

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Oral Cancer Screening

Smile Line Dentistry now offers oral cancer screening to all its patients

Benefit of Oral Cancer Screening

Oral Cancer Screening is looking for cancer before a person has any symptoms. This can help find cancer at an early stage. When abnormal tissue or cancer is found early, it may be easier to treat. By the time symptoms appear, cancer may have begun to spread.

Oral cancer screening is covered under limited insurance plans. The cost for this procedure is $49

_____ **Yes**, I am interested in getting oral cancer screening

_____ **No**, I am not interested in oral cancer screening

By signing this form, I accept/deny oral cancer test and I will be responsible for cost of the test if my insurance does not cover this procedure.

_____ (Signature)

_____ (Name of patient)

_____ (Date)

NOTICE OF PRIVACY PRACTICES AND DENTAL MATERIALS FACT SHEET

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that healthcare providers give each patient a copy of the provider's Notice of Privacy Practices, and then make a good-faith effort to obtain an acknowledgement of receipt for the notice. Patients may refuse to sign for receipt.

By signing this form, I confirm that I have received a copy of the Dental Office's Notice of Privacy Practices and a copy of the Dental Materials Fact Sheet.

_____

Patient or Parent/Guardian Printed Name

_____

Patient or Parent/Guardian Signature Date

Office Use

Written acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Unable to communicate with patient
- ☐ Emergency situation_____
- ☐ Other_____

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.

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 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. This Notice takes effect immediately, and will remain in effect until we replace it.

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 using the information listed at the end of 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 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 filled prescriptions, medical 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 authorize 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.

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. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, 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. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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. {You must make your request 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. (Your 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 receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.