Smile and Oral Health Evaluation

Thank you in advance for taking the time to allow your new dental team the opportunity to get to know you better.
Where applicable please rate your responses from 1-10 with 1 being a little and 10 being a lot.

Patient Name _____

1. How did you hear about our office?
   Explain: _____

2. What did you like about your previous dental experiences?
   Explain: _____

3. What did you not like about your previous dental experience or experiences?
   Explain: _____

4. Is there anything we can do to make your visit more comfortable? ☐Yes ☐No
   Explain: _____

5. Rate how anxious you are about dental treatment. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____

6. Rate your overall oral health. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____

7. Would you like optimal oral health care? ☐Yes ☐No
   Tell us more: _____

8. Rate the appearance of your smile. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____

9. Rate the color of your teeth? 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____

10. Rate your concern with mercury fillings. 1 2 3 4 5 6 7 8 9 10
    Tell us more: _____

11. Rate the straightness of your teeth. 1 2 3 4 5 6 7 8 9 10
    Tell us more: _____

12. Are you concerned with losing or missing teeth? ☐Yes ☐No
    Tell us more: _____

13. Is there anything we can do to enhance your smile and optimize your oral health? ☐Yes ☐No
    Tell us more: _____

PATIENT / GUARDIAN SIGNATURE	PRINTED NAME	DATE

DR.'S SIGNATURE _____ DATE _____

now! TRUSMILE

Patient Information

Patient Name:_____ Preferred Name:_____

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

Cell Phone:_____ Home Phone:_____

Email:_____ ☐Married ☐Single ☐Child

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Referred By:_____ Employer:_____

Occupation:_____ Work Phone:_____

Emergency Contact:_____ Phone:_____

Parent / Guardian Information (If under the age of 18)

Parent/Guardian Name:_____ Relationship to child:_____

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

Cell Phone:_____ Home Phone:_____

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Insurance Information

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Additional Insurance

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Authorization and Release

I authorize my insurance company to pay Smile Today all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** Smile Today may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA guidelines.

Patient/Parent or Guardian Signature **Printed Name** **Date**

Health History

To our patients: *Although oral surgeons primarily treat the area in an around your mouth, your mouth is a part of you entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care you will be receiving. Than you for answer the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

	YES	NO
1. ***Height***_____ ***Weight***_____ Are you in good health?	☐	☐
2. Have there been any changes in your general health in the past year?	☐	☐
3. Are you under the care of a physician? ***Date of last visit*** _____	☐	☐
If so, what are you being treated for? _____		
4. Have you had any illness, operation or being hospitalize in the past five years?	☐	☐
If so, describe _____		
5. Do you have unhealed/recurrent injuries or inflamed areas, growth or sore spots in or around your mouth?	☐	☐
If so, describe where _____		
6. Do you have a prosthetic joint/implant. ***If so, describe where*** _____	☐	☐
7. Have you had a heart valve replacement or vascular graft?	☐	☐
8. Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☐
9. Has a physician or previous dentist recommend that you take antibiotics prior to your dental treatment?	☐	☐

Have you had, or do you currently have?	YES	NO	NOTES
10. Rheumatic fever?			
11. Damaged heart valves/ mitral valve prolapse?			
12. Heart murmur?			
13. High blood pressure?			
14. Low blood pressure?			
15. Chest pain/angina?			
16. Heart attack(s)?			
17. Irregular heart beat?			
18. Cardiac pacemaker?			
19. Heart surgery?			
20. Pneumonia, bronchitis, chronic cough?			
21. Asthma?			
22. Hay fever/sinus problems?			
23. Snoring/sleep apnea?			
24. Difficult breathing/other lung trouble?			
25. Tuberculosis?			
26. Emphysema?			
27. Do you smoke? If so, number of packs per day? _____			
28. Do you use chewing tobacco?			
29. Blood transfusion?			
30. Blood disorder such as anemia?			
31. Bruise easily?			
32. Bleeding tendency/abnormal bleed?			
33. Hepatitis, jaundice, or liver disease?			
34. Infections mononucleosis?			
35. Gallbladder trouble?			
36. Fainting spells?			

Have you had, or do you currently have?	YES	NO	NOTES
37. Convulsions/epilepsy?			
38. Stroke?			
39. Thyroid trouble?			
40. Diabetes?			
41. Low blood sugar?			
42. Kidney trouble?			
43. High cholesterol?			
44. Are you on dialysis?			
45. Swollen ankles/arthritis/joint disease?			
46. Osteoporosis/osteopenia?			
47. Osteonecrosis?			
48. Stomach ulcers/acid reflux?			
49. Contagious diseases?			
50. Sexually transmitted diseases?			
51. Problems with immune system? Possibly from medication/surgery, etc.			
52. Delay in healing?			
53. A tumor or growth?			
54. Cancer/radiation therapy/ chemotherapy?			
55. Chronic fatigue/night sweats?			
56. Are you on a diet?			
57. A history of alcohol abuse?			
58. A history of drug abuse?			
59. Contact lenses?			
60. Eye disease/glaucoma?			
61. Mental health problems/anxiety/ depression?			
62. A removable dental appliance?			
63. Pain or clicking of the jaws when eating?			

Women Only: *Questions 64-67*

	YES	NO
64. Is there a possibility of pregnancy?	☐	☐
65. Expected delivery date? _____		
66. Are you nursing	☐	☐
67. Expected delivery date?		

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding other methods of birth control.*

Are you now taking?	YES	NO	NOTES
68. Any kind of medication, drug, pills?			
69. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish Oil?			
70. Have you ever taken diet pills?			
71. Any natural product, herbal supplement or homeopathic remedy?			
72. Are you taking, or have you ever taken, bone density meds. or bisphosphonates suck as Fosamax, Boniva, Actonel, IV-Zometa, Aredia, or Reclast in the past 12 years?			
73. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? Is so, please list:			
74. Please list any medications you are currently taking: Medication I Dosage I Frequency			

Are you allergic to, or had a reaction to?	YES	NO	NOTES
75. Local anesthetic (numbing meds.)?			
76. Penicillin?			
77. Other antibiotics?			
78. Sulfa drugs?			
79. Sodium pentothal/Valium/ other tranquilizers?			
80. Aspirin?			
81. Amoxicillin?			
82. Codeine or other narcotics?			
83. Other medications?			
84. Latex?			
85. Soy?			
86. Eggs/yolk?			
87. Sulfites?			
88. Do you have any known allergies?			
89. Please list any allergies other than drug allergies:			

If you are having surgery **today,** have you had anything to eat or drink in the last 6 (six) hours? ☐ Yes ☐ No

Who is driving you home: _____

Is there any condition concerning you health that the Doctor should be told about? ☐ Yes ☐ No - If Yes, describe

_____

Do you wish to speak to the Dr. privately about anything? ☐ Yes ☐ No

Is there a family history of:

☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthesia problem

Is this visit related to an accident? ☐ Yes ☐ No

If yes, what type of accident? ☐ Automobile ☐ Work related ☐ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney/adjustor _____

Telephone number _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that i have made in the completion of this form.

X _____ **X** _____ **X** _____

Signature of patient (Parent or Guardian if Minor) **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangement can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is no a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney fees, and court costs.

X _____ **X** _____ **X** _____

Signature of patient (Parent or Guardian if Minor) **Reviewed by** **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named in the benefits otherwise payable to me.

X _____ **X** _____ **X** _____

Signature of patient (Parent or Guardian if Minor) **Reviewed by** **Date**

I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

X _____ **X** _____ **X** _____

Signature of patient (Parent or Guardian if Minor) **Reviewed by** **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

X _____ **X** _____ **X** _____

Signature of patient (Parent or Guardian if Minor) **Reviewed by** **Date**

TruSmile *is committed to providing you with the best dental care available. We have found that a clear understanding of our office financial guidelines relieve some of the anxiety associated with going to the dentist. We want to be certain that our guidelines are clear and that all of your questions are answered to your satisfaction. For your convenience we honor several different payment plans.*

Payment Options:

When you do not have dental insurance, we ask that you pay for your dental services in full at the beginning of each appointment. We gladly accept Cash, MasterCard, Visa, Discover and American Express. We also offer TruSmile Savings Plan plan for those without insurance as an added value to you.

Dental Insurance:

As a courtesy we will file your insurance claim for you. We will make a good faith estimate for planned treatment and request that you pay your estimated portion at the time of service. When payment has been received from your insurance carrier, we will settle the outstanding balance of your account with you (there may be a difference between the estimated portion and actual payment). As a service to you, we will complete and file the appropriate claim forms with your insurance carrier(s). We are happy to provide any x-rays or additional information they might require.

If your insurer denies coverage or delays payment beyond 60 days from the claim filing date, the entire amount will become due and payable by you. Although we make every effort to help you obtain your full benefit, there are many variables we cannot anticipate nor control. Please be aware that your insurance benefits are a contract between you, your employer (if applicable) and insurance company.

Financial Services:

We offer CareCredit and Sunbit service that allows you to pay over time with convenient monthly payments.
For more information please inquire with the front office staff.

Cancelling Treatment:

We understand that sometimes a patient may find it necessary to cancel treatment that has not started or is not yet complete. If that treatment was paid in advance then you may be entitled to refund up to the full amount. In cases where treatment is in progress your prepayment will be reduced by the amount of work completed. If you only partially prepaid for this treatment, you could still have a balance due.

Refund Policy:

In the event of HSA Accounts or third party payors, like CareCredit, refunds must be processed directly back to the originator and you will receive a credit on your account as opposed to a check in the mail. Our process, including internal controls, takes about two weeks to complete.

We Would Also Like You to Know:

- Our office requires a minimum of 2 business days notice (longer if possible) if you are unable to keep your reserved appointment time.
- YOUR APPOINTMENT IS SPECIFICALLY RESERVED FOR YOU. A fee of $50 per hour of missed appointment time will be charged to the patient for any appointment that is canceled without at least two business days' notice.
- There will be a $25.00 charge for unpaid returned checks.
- $50 fee applies to retrieval or transfer of records.

I authorize payment to be made directly to TruSmile by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical information requested by my insurance carrier. I agree to pay interest of 1.5% (18% annually) on any balance over 30 days. I hereby agree that in the event of default of any amount due, and if this account is placed with a collection agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including any attorney fees and court costs incurred and permitted by laws governing these transactions up to 50% of the family's total balance.

SIGNATURE OF PATIENT / GUARDIAN

Patient/Parent or Guardian Signature	Printed Name	Date

NOTICE OF PRIVACY PRACTICES

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US!

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.

OUR PROMISE!

Dear Patient:
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office

SO WHAT HAS CHANGED?
WHY A PRIVACY POLICY NOW?
VERY GOOD QUESTIONS!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare.

The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your **HEALTH INFORMATION** only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED

TO PROVIDE TREATMENT
We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you services and/or treatment.

TO OBTAIN PAYMENT
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

TO CONDUCT HEALTH CARE OPERATIONS
Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situation experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process and certification, licensing or credentialing activities.

IN PATIENT REMINDERS
Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

ABUSE OR NEGLECT
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

PUBLIC HEALTH AND NATIONAL SECURITY
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

FOR LAW ENFORCEMENT
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

FAMILY, FRIENDS AND CAREGIVERS
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT ACKNOWLEDGMENT

PATIENT NAME: _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by your signature. We look forward to guiding you with your dental care.

PATIENT RIGHTS
This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our clients.

CONFIDENTIAL COMMUNICATIONS
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

AMEND YOUR HEALTH INFORMATION
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

DOCUMENTATION OF HEALTH INFORMATION
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

REQUEST A PAPER COPY OF THE NOTICE
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

ADDITIONAL PEOPLE WE CAN RELEASE INFORMATION TO:

_____

_____

_____

Patient/Parent or Guardian Signature **Printed Name** **Date**