WELCOME

Superb Smiles
DENTAL CARE

ABOUT YOU

Today's Date:_____/_____/_____

Patient Name:_____
LAST FIRST MI

What You Prefer To Be Called _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____

SS#:_____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____Ext. _____

Cell Phone #: _____

Email Address:_____

May we contact you at work? ❑ Yes ❑ No

Employer: _____How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Birthdate: ____/____/____ SS#: _____

Is there anyone you would like to authorize to access your records? Name:_____Relation:_____

Referred by:_____

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation:_____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____City _____

INSURANCE INFO

Primary Dental Insurance

Ins. Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Group # (Plan, Local, or Policy#): _____

- Insured's Employer:_____
- Insured's Name: _____
- Insured's SS#:_____
- Relation:_____Date of Birth:____/____/___

Secondary Dental Insurance

Ins. Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Group # (Plan, Local, or Policy#): _____

- Insured's Employer:_____
- Insured's Name: _____
- Insured's SS#:_____
- Relation:_____Date of Birth:____/____/___

Medicaid #:_____

FINANCIAL RESPONSIBILITY AGREEMENT

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance regardless of insurance. I agree to be responsible for all cost incurred to collect on my account including interest which accrues at the rate of 1.5% monthly A.P.R. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection cost, plus interest, court cost, and reasonable attorney fees.

In consideration of treatment rendered to the above named patient, I accept full financial responsibility. Insurance forms, if applicable, will be completed as a convenience to the patient, however, payment to the doctor is expected at the time services are rendered, unless other arrangements have been made with the business manager.

Signature: _____Date: _____

Please circle one: Patient Parent Guardian

PLEASE CONTINUE ON BACK

DENTAL INFORMATION

Reason for today's visit? ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes If yes, how long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw	❑ Lost/Broken Filling(s)	❑ Stained Teeth
❑ Red, swollen, or bleeding gums	❑ Teeth grinding	❑ Locking jaw
❑ Sensitive tooth, teeth, or gums	❑ Ringing in ears	❑ Bad breath
❑ Blisters/Sores in or around the mouth	❑ Broken/Chipped tooth	❑ Sinus Problems
❑ Snoring	❑ Mouth Breathing	❑ Other: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Previous Dentist: _____Phone #: (____) _____

Last Dental exam: _____/_____/_____ Last Dental x-rays: _____/_____/_____

Last Dental cleaning: _____/_____/_____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

Do you require antibiotic pre-medication for any health condition? ❑ Yes ❑ No ❑ Don't know

If yes, why? _____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Sulfa ❑ Codeine ❑ Erythromycin ❑ Others: _____

Are you taking any of the following medications? ❑ Antibiotics ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants ❑ Blood thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s), please list: _____

Do you have or have you had any of the following diseases, medical conditions, or procedures?
Circle any of the following which you have had or have at present.

Heart Attack/Chest Pains	High/Low Blood Pressure	Lung Disease	Alcohol/Drug Abuse
Heart Surg./Pacemaker	HIV+/AIDS/ARC	Diabetes/Hypoglycemia	Epilepsy/Fainting/Seizures
Heart Murmur	Artificial Joints/Bones	Hepatitis Type _____	Thyroid Problems
Rheumatic Fever	Bleeding Problems	Tuberculosis TB	Kidney Problems
Scarlet Fever	Leukemia/Anemia	Shingles	Liver Problems
Mitral Valve Prolapse	Cancer/Tumors	Venereal Disease	Intestinal Problems
Artificial Valves	Chemotherapy/radiation	Injury Face/Jaw	Stomach Problems/Ulcers
Heart Disease	Xray or Cobalt Treatment	Jaw Problems TMJ/TMD	Glaucoma
Congenital Heart Defect	Asthma	Severe/Frequent Headaches	Back/Neck Problems
Stroke	Emphysema	Frequent Neck Pain	Arthritis/Rheumatism

Please list any other medical condition(s) you have or ever had: _____

_____

Please rate your general health from 1-10: _____ (10 being the very best)

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

- I give permission for my dentist and his/her clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment.
- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.
- Authorization to release information: Dr. Ron Winters, Associates, and Authorized Personnel are authorized to provide any insurance company(s), claim administrator(s), and consulting health care professional, information concerning health care, advice, treatment, and supplies provided.
- I, the undersigned, being the patient or the parent/guardian of above minor patient, consent after consultation to the performing of whatever procedure may be determined necessary by the doctor. I authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the doctor or associates. I certify the above health history to be correct. I authorize release of my treatment record. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

Please circle one: Patient Parent Guardian

UPDATE
(OFFICE USE)

_____ ___/___/___
Initials Date

_____
Comments

_____ ___/___/___
Initials Date

_____
Comments

_____ ___/___/___
Initials Date

_____
Comments

Superb Smiles Dental Care, D.D.S.

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 _____, 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 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, or letters).

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 $ _____ 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in 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 complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to 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,

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Superb Smiles Dental Care, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign this acknowledgement*

I _____ , have received a copy of this Office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____