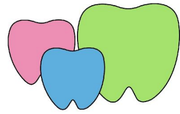

Modern Day Smiles
General, Cosmetic and Emergency Dentistry

MEDICAL HISTORY

General Information
Name (First, M. Last): ____________________________ Today's Date: ____________________________
Address: ____ City: ______________ State: ______ Zip Code: _________
Cell Phone #:____________________ Work Phone #:________________________
Email Address:____________________________ Date of Birth:___________________________
Social Security Number:___________________________ Driver's License Number:______________________________
Emergency Contact (Name/Relationship/Phone Number): ____

Dental Information (Yes/No & Details)
Main Reason for Today's Visit? ____
Who should we thank for your Referral? ____
Tooth Pain? _________________________________ Jaw Pain (clicking/popping)? ______________________________
Bleeding Gums? _____________________________ Cold/Hot/Sweets/Pressure Sensitive teeth? ________________________
Mouth Dry/Sore? ____________________________ Past "Deep Cleaning"/ Gum Treatments?____________________________
Grind your teeth? _____________________________Snoring?____
Last Dental Exam or Cleaning (Where & Date):____

Medical Information (Primary Care, Internal or Family Medicine)
Physician Name: ____
Address: ____City: ________________________ State:_____ Zip Code:________
Phone: ____________________________ Fax: ____________________________ Email: ________________________________
Are you in good health? ____________________________ Last Checkup? ______________________________________
Any serious illness/conditions, operations or hospitalizations within the last 5 years? (Date & Details)____
____

Medications? (List all names including vitamins, please give the receptionist a full copy)____
____
____

Medical Allergies (Yes/No & Details)
Local Anesthetic (Dental)?___________________________Penicillin (or any other antibiotics)?_________________________
Barbiturates, Sleeping Pills, Sedatives?____________________________
Sulfa?____
Codeine/Narcotics?______________________ Metals?____________________________ Latex?___________________
Certain Foods?____________________________ Seasonal Allergies?______________ Other?_______________________

Medical Information (Yes/No & Details with Date of Treatment/Diagnosis)
Joint Replacement?_______________________________ Artificial Heart Valve?_______________________________________
Heart Surgery/Pacemaker?__________________________ Heart Attack (Myocardial Infarction)?___________________________
Previous Infective Endocarditis?____________________ Congenital Heart Disease?_______________________________________
Anemia/Abnormal bleeding?________________________ High/Low Blood Pressure?______________________________________
Diabetic (Type 1 or 2)?____________________________ Stroke?____
Asthma?____COPD/Emphysema?______________________________________
Osteoporosis?____________________________________ Arthritis/Joint Pain?____
Cancer/Chemotherapy? ____________________________ Radiation? ____
Seizures/Epilepsy?________________________________ Swollen Glands?____

(continued)

Tobacco?______________________________________Any other controlled substances?_______________________
Chronic Diseases / Other Chronic Conditions (ie STDs, HIV/AIDS, etc)? ____
(For Women)
Pregnant (If so, how many months)?_________________________ Nursing?___________________________________

Please discuss any and all relevant patient health issues prior to treatment.
I acknowledge my questions and concerns have been answered and I have filled in this form truthfully and accurately.

X **Signature: _______________________________________Date: ___________________________**

FINANCIAL POLICY

The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, money orders, MasterCard, Visa, American Express and Discover. Outside financing is available upon request and approval. Drivers Licenses may be confirmed when paying by check.
Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges which may be based on a percentage of up to 33% maximum of accounts balance.
• As a courtesy to you we will help you process your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
• All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.
• You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
• We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
• We ask that you pay the deductible and co-payment, at the time we provide the service to you.
• Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. **If payment is not received or your claim is denied, you will be ultimately responsible for paying the full balance amount.**

Appointment Policy: Appointments are reserved especially for you! A notice of at least 48 hours must be given for cancellation or rescheduling of appointments. A fee of a minimum of $50 and/or up to 100% of your scheduled appointment amount will be charged TO YOU, for last minute cancellations or "No Show" appointments.

Consent:
I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MODERN DAY SMILES. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.
By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose.

X **Signature: _______________________________________Date: ___________________________**

HIPAA (Health Insurance Portability and Accountability Act)

HIPAA was designed to protect patient information and associated sensitive data. This serves as our notice of privacy practices for all our patients.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION: We will keep your health information confidential, using it only for the following purposes: **Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
Disclosure: We may disclose and/or share your health care information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.
Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.
Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers, and individuals performing similar activities.
Required by Law: We may use or disclose your health information when we are required to do so by law: court or administrative orders, subpoena, discovery request or other lawful process. We will use and disclose your information when requested by national security intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability.
Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.
National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT: **Access:** Upon written request, you have the right to inspect and get copies of your health information, and that of an individual for whom you are a legal guardian. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an

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appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page up to 25 pages, then 25 cents each page thereafter, and the staff time charged will be $50.00 per hour including the time required to locate and copy your health information. If you want the copies mailed if you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your health care information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-Routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back six (6) years starting on April 14. 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies) This request must be submitted in writing.

Please discuss any and all relevant patient HIPAA concerns prior to any treatment.
I acknowledge my questions and concerns have been answered and I have read this form in entirety.

Signature: ____Date: ____________________________