



# Smile Evaluation

1. Do you like the way your teeth look?    Yes     No   
Explain: \_\_\_\_\_
2. Are you happy with the color of your teeth?    Yes     No   
Explain: \_\_\_\_\_
3. Would you like for your teeth to be whiter?    Yes     No   
Explain: \_\_\_\_\_
4. Would you like for your teeth to be straighter?    Yes     No   
Explain: \_\_\_\_\_
5. Do you have spaces between your teeth you would like closed?    Yes     No   
Explain: \_\_\_\_\_
6. Would you like your teeth to be longer?    Yes     No   
Explain: \_\_\_\_\_
7. Do you like the shape of your teeth?    Yes     No   
Explain: \_\_\_\_\_
8. Do you have missing teeth that you would like to replace?    Yes     No   
Explain: \_\_\_\_\_
9. Do you have old silver fillings you would like to replace with tooth colored fillings?    Yes     No   
Explain: \_\_\_\_\_
10. If you could change anything about your smile what would you change?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have any additional questions or concerns about your smile or teeth please ask one of our staff members and they will let the doctor know. Thank you



**Patient Information**

Patient Name:		Preferred Name:	
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
Email:			Marital Status: Married / Single / Child
Sex: Male / Female	Age:	DOB:	Social Security#:
Employer:		Occupation:	
Work Address:			
Emergency Contact:		Address:	Phone:

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

Parent/Guardian Name:		Relationship to Child:	
Home Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	
Sex:	Age:	DOB:	Social Security#:
Employer:		Occupation:	
Work Address:			Work Phone:

**Insurance Information**

Primary Insured (Subscriber):			
Relationship to Patient:	Date of Birth:	Subscriber ID#:	Group#:
Subscriber Employer or Plan Sponsor:			
Insurance Company:			

**Additional Insurance**

Secondary Insured (Subscriber):			
Relationship to Patient:	Date of Birth:	Subscriber ID#:	Group#:
Subscriber Employer or Plan Sponsor:			
Insurance Company:			

**Authorization and Release**

I authorize my insurance company to pay My Family Dental Centers all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. My Family Dental Centers 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 HIPPA guidelines.

Patient/Parent or Guardian Signature

Printed Name

Date

## DENTAL HISTORY

REASON FOR TODAY'S VISIT: \_\_\_\_\_

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT THE APPEARANCE OF YOUR SMILE? \_\_\_\_\_

HOW OFTEN DO YOU BRUSH? \_\_\_\_\_ HOW OFTEN DO YOU FLOSS? \_\_\_\_\_

DATE OF LAST DENTAL CLEANING: \_\_\_\_\_ DATE OF LAST DENTAL X-RAYS/EXAM: \_\_\_\_\_

MARK IF YOU HAVE HAD/HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> BAD BREATH                    | <input type="checkbox"/> BLEEDING GUMS                 | <input type="checkbox"/> JAW PAIN                | <input type="checkbox"/> SENSITIVITY TO COLD/HOT |
| <input type="checkbox"/> LOOSE OR BROKEN TEETH         | <input type="checkbox"/> LOOSE OR BROKEN FILLINGS      | <input type="checkbox"/> CLICKING OR POPPING JAW | <input type="checkbox"/> GRINDING TEETH          |
| <input type="checkbox"/> SENSITIVITY TO SWEETS         | <input type="checkbox"/> SORES OR GROWTHS IN THE MOUTH | <input type="checkbox"/> SENSITIVITY WHEN BITING |  |
| <input type="checkbox"/> FOOD COLLECTION BETWEEN TEETH |  |  |  |

## MEDICAL HISTORY

PHYSICIANS NAME: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? YES / NO

IF YES, DESCRIBE: \_\_\_\_\_

HAVE YOU HAD A BLOOD TRANSFUSION? YES / NO

IF YES, GIVE APPROXIMATE DATE(S): \_\_\_\_\_

HAS IT EVER BEEN NECESSARY FOR YOU TO PRE-MEDICATE FOR A DENTAL APPOINTMENT? YES / NO

IF YES, DESCRIBE: \_\_\_\_\_

ARE YOU/HAVE YOU TAKEN ANY BISPHOSPHONATE MEDICATION? YES / NO

IF YES, DESCRIBE: \_\_\_\_\_

CIRCLE ANY OF THE FOLLOWING CONDITIONS, PAST OR PRESENT:

ANEMIA	YES/NO	CIRCULATORY PROBLEMS	YES/NO	HEPATITIS	YES/NO	SCARLET FEVER	YES/NO
ARTHRITIS, RHEUMATISM	YES/NO	CORTISONE TREATMENT	YES/NO	HIGH BLOOD PRESSURE	YES/NO	SHORTNESS OF BREATH	YES/NO
ARTIFICIAL HEART VALVES	YES/NO	PERSISTENT COUGH	YES/NO	HIV/AIDS	YES/NO	STROKE	YES/NO
ARTIFICIAL JOINTS	YES/NO	DIABETES	YES/NO	KIDNEY DISEASE	YES/NO	SWELLING OF FEET / ANKLES	YES/NO
ASTHMA	YES/NO	EPILEPSY	YES/NO	LIVER DISEASE	YES/NO	THYROID PROBLEMS	YES/NO
BACK PROBLEMS	YES/NO	FAINTING	YES/NO	MITRAL VALVE PROLAPSE	YES/NO	TOBACCO USAGE	YES/NO
BLOOD DISEASE	YES/NO	GLAUCOMA	YES/NO	PACEMAKER	YES/NO	TUBERCULOSIS	YES/NO
CANCER	YES/NO	HEART MURMUR	YES/NO	RADIATION TREATMENT	YES/NO	TONSILLITIS	YES/NO
CHEMOTHERAPY	YES/NO	HEART PROBLEMS	YES/NO	RESPIRATORY DISEASE	YES/NO	ULCERS	YES/NO
CHEMICAL DEPENDENCY	YES/NO	HEMOPHILIA	YES/NO	RHEUMATIC FEVER	YES/NO	VENEREAL DISEASE	YES/NO

WOMEN: ARE YOU PREGNANT? YES / NO ARE YOU NURSING? YES / NO TAKING BIRTH CONTROL? YES / NO

LIST MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

LIST ANY ALLERGIES YOU ARE AWARE OF: \_\_\_\_\_

## IN OFFICE USE

HEAD & NECK EXAM WNL or \_\_\_\_\_  
SOFT TISSUE WNL or \_\_\_\_\_  
TMJ EXAM WNL or \_\_\_\_\_  
OCCLUSION CLASS I II III  
ORTHO YES NO

## UPDATED MEDICAL HISTORY

\_\_\_\_\_  
( DATE / INITIAL ) \_\_\_\_\_ ( DATE / INITIAL )  
\_\_\_\_\_  
( DATE / INITIAL ) \_\_\_\_\_ ( DATE / INITIAL )  
\_\_\_\_\_  
( DATE / INITIAL ) \_\_\_\_\_ ( DATE / INITIAL )  
\_\_\_\_\_  
( DATE / INITIAL ) \_\_\_\_\_ ( DATE / INITIAL )

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS ACCURATE AND COMPLETE. I WILL NOT HOLD THE DOCTOR OR ANY MEMBERS OF THEIR STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE:

\_\_\_\_\_  
PRINTED NAME:

\_\_\_\_\_  
DATE:

\_\_\_\_\_  
DR.'S SIGNATURE:

\_\_\_\_\_  
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 (HIPPA – 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.



# Financial Guidelines

*Mountainside Family Dental 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 end of each appointment. We gladly accept Cash, MasterCard, Visa, Discover and American Express.

## **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. Please be aware that your insurance benefits are a contract between you, your employer (if applicable) and insurance company.

## **Financial Services:**

We offer CareCredit or Chase Health Advance plans that allow you to pay over time with convenient monthly payments including several interest deferred options. For more information please inquire with the front office staff.

Are you interested in interest deferred financing with monthly payments?

## **We Would Also Like You to Know:**

- Our office requires a minimum of 48 hours 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 cancelled without at least two business days notice.
- There will be a \$25.00 charge for unpaid returned checks.

I authorize payment to be made directly to Mountainside Family Dental 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 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.

## **Signature of Patient/Guardian**

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Patient/Guardian Signature

Printed Name

Date