IMPLANT
SMILE STUDIO

Name : _____ Date of Birth: _____

Preferred Name : _____ SSN : _____

Email Address : _____

How did you hear about us? _____

Street Address : _____ City/State/Zip_____

Cell Phone: _____ Work Phone: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

PLEASE NOTE: *By providing the above contact information, you agree that the information is correct, and you agree for our office to utilize this information to contact you regarding any communication.*

Emergency Contact Person: _____

Relation: _____ Phone #: _____

By listing a contact person about you agree for our office to disclose any and all pertinent information regarding your care to person listed above in the event of an emergency.

DENTAL INSURANCE SUBSCRIBER

Name: _____ Date of Birth: _____

Employer: _____ SSN: _____

Dental Insurance: _____ Policy/Subscriber #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ DL#: _____

Signature _____ Date: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I understand I and solely responsible for any balances not paid by my insurance company.

DENTAL AND HEALTH HISTORY

Reason(s) for today's visit: ____ New Patient ____ Emergency (Are you in pain? - Y / N)

If yes, how long? _____

Are you you having any of the following problems: *(circle all that apply)*

Bad breath / Blisters / Sores / Discomfort, clicking, popping in jaw / Locking jaw

Red, swollen, bleeding gums / Sensitive teeth or gums / Stained Teeth / Teeth grinding

Broken or lost: Fillings / Broken or chipped: Teeth

DENTAL AND HEALTH HISTORY CONTINUED

What type of toothbrush do you use? ____ Soft ____ Medium ____ Hard

How many times a day do you brush? _____ How many times a week do you floss? _____

What would you like to change about your smile? _____

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

Previous Dentist: _____ Date of last exam: _____

Medical Doctor: _____ Phone Number: _____

Are you taking any medications or supplements? **Yes** or **No** if yes, please list the names:

_____

_____

Are you currently taking any **BLOOD THINNERS** (including Aspirin, Plavix, Coumadin, Xareltor, Brilinta)

Yes or **No** If yes, what?_____

Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Alcohol/Drug Abuse	☐	☐	Emphysema	☐	☐	Mitral Valve Prolapse
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Nervousness
☐	☐	Arthritis/Rhuematism	☐	☐	Heart Attack/Stroke	☐	☐	Pacemaker
☐	☐	Artificial Valves	☐	☐	Heart Disease	☐	☐	Psychiatric Problems
☐	☐	Asthma/Difficulty Breathing	☐	☐	Heart Murmur	☐	☐	Respiratory Problems
			☐	☐	Heart Surgery	☐	☐	Rheumatic Fever
☐	☐	Back Problems	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Bleeding Problems	☐	☐	High/Low Blood Pressure	☐	☐	Seizures/Fainting
☐	☐	Cancer	☐	☐	HIV+/AIDS/ARC	☐	☐	Shingles
☐	☐	Chemotherapy	☐	☐	Jaw Problems	☐	☐	Stomach Problems
☐	☐	Chest Pains	☐	☐	Kidney Problems	☐	☐	Thyroid Problems
☐	☐	Congenital Heart Disease	☐	☐	Leukemia	☐	☐	Tuberculosis (TB)
☐	☐	Cosmetic Surgery	☐	☐	Liver Problems	☐	☐	Veneral Disease
☐	☐	Diabetes/Hypoglycemia	☐	☐	Migraines/Headaches			

Text

Please list any other ***medical conditions*** or ***surgeries*** you have had_____

_____

Are you allergic to any of the following? (circle all that apply)

Penicillin **Amoxicillin** **Tetracycline** **Local Anesthetic**

Codeine **Latex** **Sulfa** **Other** _____

Do you use tobacco products? **Yes** or **No** How many packs/day and how long? _____

Rate your general health 1 2 3 4 5 6 7 8 9 10

WOMEN ONLY Are you pregnant? **Yes** or **No** If yes, how many weeks? _____

Are you nursing? **Yes** or **No** Do you take birth control or hormone pills? **Yes** or **No**

PHOTO AND VIDEO CONSENT

PLEASE READ BELOW FOR DETAILED INFORMATION ON OUR PRACTICE'S PHOTO CONSENT

BEFORE AND AFTER PHOTOS

These photos are taken prior to any esthetic dental work here at Peak Dental. This form is to give us your permission to use such photographs for marketing purposes.

These photographs are taken of the ***teeth only***, no faces or names are used for these purposes. On occasion we do post video clips in office of procedures being performed as well. If you authorize the use of these photographs/videos. *Please sign the form at the bottom granting us your permission* for such usage.

REVOCABILITY

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice to be scanned into patient chart. This authorization expires 99 years from date signed.

NO TREATMENT CONDITIONS

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

CONSENT

I authorize the use and disclosure by the Peak Dental. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPPA privacy regulations.

Patient Name *(print)*_____

Patient Signature *(or guardian)* _____

Date_____

FINANCIAL POLICY

PLEASE READ BELOW FOR DETAILED INFORMATION ON OUR PRACTICE'S FINANCIAL POLICY

INSURANCE

Much confusion exists regarding dental insurance payments. Your dental insurance plan is a contract between **you and your insurance company.** Because the terms of all plans and policies differ, you should be familiar with the specific terms of your policy. Although the filing of insurance claims is a courtesy that we extend to our patients to facilitate their prompt reimbursement, please understand that the payment of all fees is *your* responsibility.

Our office does not participate with all insurance plans, however we do file with all insurance companies on your behalf. Our patients are, however, responsible for any ***ESTIMATED*** co-payment and amounts not covered by their insurance plan at the time services are rendered. If your copay is underestimated, you are **ALWAYS** responsible for the remaining balance on your account.

COLLECTIONS

Accounts without a payment agreement that have a balance over ***30 days*** will be considered overdue. These accounts are due immediately, regardless of insurance status. Returned checks will be subject to an administration fee of $30. The patient, parent and/or guardian shall be responsible for payment of all procedures performed in this office, including any treatment not covered by any dental insurance. Any account more than ***45 days*** overdue will be sent to a collection agency. These accounts will be subject to an additional 30% of the overdue balance in order to cover the costs incurred by the collection agency

CONSENT

I certify that I have read, understood and agree to the terms. I understand I am able to request a copy of this financial policy at any time.

Patient Name *(print)* _____

Patient Signature *(or guardian)* _____

Date_____

APPOINTMENT POLICY

PLEASE READ BELOW FOR DETAILED INFORMATION ON OUR PRACTICE'S FINANCIAL POLICY

CANCELLATIONS

We realize that your time is valuable, and in order to minimize waiting, we reserve appointment times especially for you. We ask that you show us the same courtesy. If you are unable to keep your appointment, please notify the office at least ***48 hours*** prior to your appointment. We reserve the right to charge you a same day cancellation fee of $25 if you give less than ***24 hours*** notice or a $50 no show fee. This is to compensate for lost time and money.

PLEASE NOTE, WE DO NOT ACCEPT CANCELLATIONS AFTER BUSINESS HOURS.

DEPOSITS

To reserve future treatment appointments with our office, we require a deposit and ask that you leave a credit card on file. ***48 hour*** notice will be required to cancel or reschedule. We reserve the right to keep all or part of your deposit if less that ***24 hours*** is given. This is to compensate for lost time and money. In the event you don't call or you no-show for your appointment, your entire deposit will be lost. If you reschedule with proper notice, your deposit may be applied to another appointment.

PLEASE NOTE, WE DO NOT ACCEPT CANCELLATIONS AFTER BUSINESS HOURS.

LATE ARRIVAL

If you know that you will be arriving to your appointment late, we ask that you call the office and let us know. If you will be more than 10 minutes late, we will need to reschedule your appointment. This is to respect the time for the next patient and office.

CONSENT

I certify that I have read, understood and agree to the terms. I understand I am able to request a copy of this financial policy at any time.

Patient Name_____ **Name on Card**_____

Credit Card Number_____ **EXP**_____ **CV**_____

Patient Signature *(or guardian)*_____ **Date**_____

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowl- edge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer _____

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