Please bring with you to your first appointment :

- **Photo ID (if over 18)**
- **Dental Insurance card (if applicable)**
- **Medical Insurance card**

PATIENT INFORMATION:

First Name: ____________________MI: ___ Last: __________________________ Preferred Name:_____________

DOB: _________________________ ◻ Male ◻ Female Soc.Sec. #: ________________________________

Address:______________________________________ City:__________________ State:______ Zip:____________

Home Phone:___________________ Work Phone:____________________ Cell Phone:______________________

E-mail Address: ____

Preferred contact method? (Please Circle) Home Work Cell No Preference

Employer or School/College(if student): ____

Emergency Contact: ________________________ Relationship: _______________ Phone: ___________________

Whom may we thank for referring you to our office? ____

DENTAL INSURANCE INFORMATION:

Primary Insurance:

Insurance Name:____Employer:_________________________

Subscriber: __________________________ DOB: ___________________Relationship:_______________________

Subscriber ID/SSN: ____________________Group #:_________________Phone #: __________________________

Secondary Insurance:

Insurance Name:____Employer:_________________________

Subscriber: __________________________ DOB: ___________________Relationship:_______________________

Subscriber ID/SSN: ____________________Group #:_________________Phone #: __________________________

DENTAL HISTORY/ORAL HEALTH:

Previous Dentist:_____________________________ Date of Last Dental Visit:_____________________________

Date of last dental cleaning: ____________________ How often did you visit before that:____________________

What was done at your last visit (circle): XRAYS CLEANING OTHER: __________________________________

How often do you brush? ______________________ How often do you floss? _____________________________

Please indicate if you have had any of the following:

____ Bad Breath
____ Swollen or Bleeding Gums
____ Smoking, Vaping, Cigar, Pipe
____ Chewing Tobacco
____ Loose Teeth or Broken Fillings
____ Food Collection between teeth
____ Grinding or Clenching Teeth
____ Headaches
____ Sensitivity to hot, cold, or pressure
____ Sores or blisters on lips/mouth
____ Orthodontic Treatment
____ Periodontal Treatment
____ Earaches or Ear ringing
____ Jaw Pain or Tiredness
____ Clicking or Popping Jaw

How happy are you with your smile(1-10)? (1= Not at all Happy, 10=I Love my smile!) _______________________

Is there anything you would like to change? ____

MEDICAL CONDITIONS (CHECK ALL THAT APPLY):

____ADD/ADHD
____AIDS/HIV
____Allergies (seasonal)
____Anemia
____Anxiety/Depression
____Arthritis_________________
____Artificial Joints ___________
____Asthma
____Cancer _________________
____Chemical Dependency
____Diabetes Type ___________
(A1C ________) or Pre-Diabetes
____Epilepsy/Seizures
____Fainting or Dizziness
____Artificial Heart Valve /MVP
____Heart Condition_________
____Hepatitis, Type_________
____Herpes, Type_________
____High/Low Blood Pressure
____HPV
____Kidney Condition
____Liver Condition
____Pacemaker ____________
____Psychiatric Care
____Radiation Treatment
____Respiratory Disease
____Rheumatic Fever
____Shingles
____Sinus Condition
____Stroke
____Thyroid Condition ________
____Tinnitus/Vertigo
____Tuberculosis
____Ulcer
____Other___________________
____

WOMEN ONLY:

A) Are you pregnant? Yes No
B) Are you nursing? Yes No
C) Is there any chance that you may be pregnant? Yes No
D) Are you taking Birth Control? Yes No

MEDICAL HISTORY:

Physician:____ Office Phone: ______________________________

Are you under medical treatment now for a current ongoing condition? Yes No
Have you ever been hospitalized for any surgical operation or serious illness? Yes No
Are you allergic to any of the following?

____ ASPIRIN ____ LOCAL ANESTHETICS ____ CODEINE ____ PENICILLIN ____ LATEX
____ OTHER ____

Has your physician ever indicated that you should have Pre-Medication before dental treatment? Yes No
Have you ever had any complications following dental treatment? Yes No
Are you taking a blood thinner? Yes No
Are you receiving Hormone Replacement Therapy (HRT)? Yes No
Are you taking or have you ever taken bisphosphonates? Yes No

Please list all medications (or attach list):
____
____

PHOTOGRAPHIC RELEASE

Your initials indicate your consent for New Albany Smiles to use, reproduce and publish photographic/computer illustrations of your teeth/mouth for illustrative and educational purposes. It is not mandatory and is done freely and voluntarily.
Patient Initial __________

AUTHORIZATION

I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. I certify that I have read and understand the questions, above. The answers provided on this dental and medical history are correct and to the best of my knowledge.

Patient Name (Print)____

Signature (Patient or Parent/Guardian) _________________________________ Date ______________________

Doctor Signature ____ Date ______________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health/dental information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up with the multiple healthcare providers who may be involved directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

An official *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information is available upon request. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this dental practice to obtain a current copy of the *Notice of Privacy Practices.*

HIPAA Health Information Sharing Release:

I,____, hereby authorize the following person(s) the ability to disclose and release of any of my individual personal information pertaining to past, present or future dental health treatment to any of my immediate family members.

Name______________________________________ Relationship_________________

Name______________________________________ Relationship_________________

(a) Request, review and receive any form of dental information, oral or written including clinical notes, x-rays, treatment plans needed, completed dentistry, dental insurance, and finances associated with any or all of my dental treatment.

(b) Can execute on my behalf any releases or documents that may be required in order to obtain information including, but not limited to: Valid Authorization to share information under the Ohio Confidentiality of Dental Information Act and Insurance Portability and Accountability Act.

This authorization is effective immediately and has no written expiration date. I understand that I have the right to revoke the authority in writing at any time and deliver it to my dental care provider.

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

____

Patient Name (Print)

____ ____________________

Signature (Patient or Parent/Guardian) Date

FINANCIAL POLICY

Payment Agreement:

I agree that I am responsible for all services rendered and that payment is due at the time treatment is rendered and that all insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service. We are happy to provide you with an estimate in advance (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage).

I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered.

Financial Agreement:

I understand that the Practice may charge: 1) a fee for each appointment that is missed/cancelled without at least 24 hours advance notice. 2) a finance charge (interest at a rate of 1.5%) if payment on my account is not received by the due date; and 3) Returned checks will be subject to a fee of $35.00. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees, collection charges, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

Initial: _____ **Patient co-pays are due the same day service is rendered. Statement balances are due at the time of receipt.**

Initial: _____ **We respectfully ask our patients to arrive on time and keep all reserved appointments with us.** We will try to remind you by telephone, text and/or e-mail prior to your scheduled time, but please do not rely upon this courtesy. If **you are unable, for any reason, to keep your previously reserved time with us, we require <u>a minimum of 2 business days</u>** to avoid a possible lost time charge of $65.00 or 1/3 the value of the lost appointment time to your account.

We are committed to providing you with the best and most comfortable care in a positive environment, while helping you understand your responsibilities to our practice. We do understand that emergencies can occur, and request that you contact our office to avoid any misunderstandings in regard to your account.

I have read, initialized at the appropriate areas, and agree to the terms listed above.

____
Patient Name (Print)

______________________________________ ________________
Signature (Patient or Parent/Guardian) Date