SMILES
AUSTIN | DRIPPING SPRINGS
Orthodontics and Pediatric Dentistry

Date ________________________

PATIENT INFORMATION

Name ________________________ Birth date ________________________

Preferred name ________________________ Primary phone number ________________________ Gender: M F N/A

Address ________________________ City ______________ State ________ Zip ____________

Email ________________________ Employer________________________

Whom may we thank for referring you to our office ________________________

Dentist________________________ Date of last cleaning________________________

Main concerns that you would like orthodontics to accomplish________________________

Have you visited an orthodontist before? YES NO If YES, for what reason?________________________

Have we treated another member of your family? Yes No If YES, Name(s):

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EMERGENCY CONTACT

Name________________________ Phone number________________________

Relationship________________________

SPOUSE'S INFORMATION (*if applicable*)

Name ________________________ Birth date ________________________

Primary phone number ________________________ Email ________________________

DENTAL INSURANCE INFORMATION (*if applicable*)

Subscriber's name ________________________ Subscriber's birth date ________________________

Subscriber's SS# ________________________ Subscriber's ID# ________________________

Insurance company ________________________ Group or plan # ________________________

Insurance company address ________________________

Insurance company phone # ________________________ Subscriber's employer ________________________

Your answers are for office records only and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions, please mark yes, no, or don't know/understand. Please provide explanation for any "yes" answers.

Medical History

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Stomach ulcer, hyperacidity, acid reflux?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Do you eat a well-balanced diet?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following?

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances ______________________________

Dental History

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Bleeding gums, bad taste or mouth odor?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ "Gum boils," frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Food impaction between the teeth?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Abnormal swallowing (tongue thrust)?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Ringing in ears, difficulty in chewing or opening jaw?
- ☐ ☐ ☐ Have you ever been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Have you ever been diagnosed with gum disease or pyorrhea?
- ☐ ☐ ☐ Have you ever had an orthodontic consultation or treatment before now?

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you are taking.

Medication ______________________________________ Taken for ____

Medication ______________________________________ Taken for ____

Medication ______________________________________ Taken for ____

Medication ______________________________________ Taken for ____

Have you ever taken any medications to strengthen your bones? Please describe. ____

____

Do you take antibiotic pre-medication before any dental procedures? ____

Do you or have you ever had a substance abuse problem? ____

Do you chew or smoke tobacco? ____

Have you noticed any changes in your face or jaws? ____

Do you have any other medical problems you would like us to be aware of? ____

How often do you brush? ____ How often do you floss? _______________________________

Women: Are you pregnant? □ Yes □ No Are you trying to become pregnant? □ Yes □ No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders ____ Diabetes ____

Arthritis ____ Severe allergies ____

Unusual dental problems _____________________________________ Jaw size imbalance ____

Are there any other family medical conditions? ____

RELEASE AND WAIVER

The information I have provided is accurate to the best of my knowledge, and I will notify my orthodontist of any changes in my medical or dental health. I consent to full diagnostic records including, but not limited to, x-rays and an exam by the orthodontist. I understand and acknowledge the orthodontic records taken today are complimentary if used by the orthodontists at Smiles of Austin, though the value of these records is $400. Should I wish to have my records transferred to a different orthodontist, there is a fee to obtain my records. I authorize the release of any pertinent information regarding my orthodontic treatment to my dental and/or medical insurance carrier.

Signature____ Date____

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OFFICE POLICIES

(Please initial the following)

_____ Payments: Payment for professional services is due at the time services are rendered. This includes any deductible and co-insurance. We accept cash, checks, all major credit cards, and Care Credit. Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued and is overdue if not paid by twenty-one (21) days after the statement date.

_____ Treatment Plans: If Smiles of Austin/Dripping Springs has treatment recommendations for you/your child, you will receive an itemized list of the recommended treatment along with an estimate of the fees. If you have dental insurance, the treatment plan may include an additional estimate calculating what may be paid by your insurance company. Treatment plan estimates are not a guarantee of insurance payment, and you are ultimately responsible for all fees.

_____ Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance company, as a courtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by treatment. If your insurance company has not paid your claim within ninety (90) days after the date of service, the full amount is due and payable by you. We will promptly refund to you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage.

_____ Past Due Accounts: If your account becomes delinquent, we will take necessary steps to collect this debt. If we must refer your account to a collections agency, you agree to pay all collection costs incurred.

_____ Returned Checks: There is a $25 fee for any checks returned by the bank.

_____ Insurance Release: You authorize Smiles of Austin/Dripping Springs to release any necessary information requested by insurance carrier and authorize payment directly to us for any available insurance benefits.

_____ Divorce: In case of a divorce or separation, the parent who authorized treatment prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent. The doctors and staff at Smiles of Austin/Smiles of Dripping Springs are not mediators and will not serve as mediators under any circumstances.

_____ Late Arrivals: To respect the time of other patients, we may find it necessary to reschedule those patients arriving more than 10 minutes late for their appointment.

_____ Canceled Appointments: We kindly ask for two business days' notice for rescheduling appointments. Depending on the appointment type, a fee may be assessed for the missed appointment.

DENTAL INSURANCE FACTS

FACT 1 – DENTAL INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. We are not a party to that contract.

FACT 2 – INSURANCE USUALLY DOES NOT PAY 100% OF ALL PROCEDURES. It is not meant to cover all fees, but to be an aid in receiving dental care for your child. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company. Many routine dental services are not covered by dental insurance.

FACT 3 – BENEFITS MAY HAVE FREQUENCIES AND LIMITATIONS. The frequency of payment for some procedures may be limited by an insurance company. We will do our best to obtain accurate coverage information for all procedures and inform the financially responsible party ahead of time, but we will make treatment recommendations on what is in the best interest of the child, not the insurance company. This may include diagnostic, preventative, and restorative services.

FACT 4 – BENEFITS ARE NOT DETERMINED BY OUR OFFICE. Sometimes your insurance carrier reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") they consider allowable. "Allowable" fees are set by the insurance company so they can make a profit. Unfortunately, insurance companies imply that your dentist is "overcharging," rather than say that they are "underpaying," or that their benefits are unrealistically low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

FACT 5 – DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED. Deductibles and percentages must be considered when estimating benefits and may impact the patients' out of pocket cost.
Your clear understanding of our office policies is important to our professional relationship and we welcome your questions and feedback anytime.

Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees or financial policy.

PATIENT NAME: _____________________________________ DATE OF BIRTH: ________________________

RESPONSIBLE PARTY NAME: __________________________ RELATIONSHIP TO PATIENT: _______________

SIGNATURE: ____ DATE: ______________________________

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NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:
You can ask us to correct health information about you that is incorrect or incomplete. Ask us how to do this.We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you:
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:
You can complain if you feel we have violated your rights by contacting us using the information listed below. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 2021, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choices to tell us to:
Share information with your family, close friends, or others involved in your care.
Share information in a disaster relief situation.

Include your information in a hospital directory
If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and safety.

In these cases, we never share your information unless you give us written permission:
Marketing purposes.
Sale of your information.
Most sharing of psychotherapy notes.

In the case of fundraising:
We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways:
- We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.
- We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.
- We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

We can share health information about you for certain situations such as:
- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.
- We can use or share your information for health research.
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

We can use or share health information about you:
- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions, such as military, national security, and presidential protective services.
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

______________________________	______________________________	__________
Signature	Printed Name	Date