SMILES
AUSTIN | DRIPPING SPRINGS
Orthodontics and Pediatric Dentistry

Welcome to your orthodontic home! Please complete ALL fields so we can better serve you.

PATIENT INFORMATION

Date _____

Name of child _____ Birth date _____ Age _____

Preferred name _____ Home phone _____ Gender _____

Address _____ City _____ State _____ Zip _____

Best contact to confirm appointments: Cell phone _____ Email _____

Whom may we thank for referring you to our office? _____ Child's school _____

Is this your child's first visit to an orthodontist? ☐YES ☐NO Orthodontist previously seen _____

ADDITIONAL FAMILY MEMBERS (*children/siblings including birthdates*)

_____

_____

PARENT/GUARDIAN INFORMATION (*please list both if applicable*)

Name _____

Birth date _____

Relationship to child _____

Marital status _____

Address _____

City _____ State _____ Zip_____

Home phone _____ Cell _____

Email _____

Employer _____

SSN _____

Financially Responsible for Dental Services? ☐Yes ☐No

Name _____

Birth date _____

Relationship to child _____

Marital status _____

Address _____

City _____ State _____ Zip_____

Home phone _____ Cell _____

Email _____

Employer _____

SSN _____

Financially Responsible for Dental Services? ☐Yes ☐No

EMERGENCY INFORMATION (*person not living with the patient*)

Emergency contact name _____

Address _____

Home phone _____ Cell phone _____

DENTAL INSURANCE INFORMATION

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 _____

HEALTH STATUS

Please list all current medications (including over the counter) _____

_____

Patient's current physical health _____

Patient's current mental health _____

MEDICAL HISTORY (*please provide explanation for any "yes" answers)*

☐ Yes ☐ No Airway problems (snoring, sleep apnea, asthma, mouth breathing, tonsillectomy, other)? _____

_____

☐ Yes ☐ No Allergies (latex, food, drug, nickel, other)? _____

_____

☐ Yes ☐ No Blood disorders (prolonged bleeding, anemia, other)? _____

_____

☐ Yes ☐ No Circulatory problems (high blood pressure, heart murmur, antibiotic premedication, other)? _____

_____

☐ Yes ☐ No Communicable disease (HIV, hepatitis, tuberculosis, other)? _____

_____

☐ Yes ☐ No Immune problems (diabetes, AIDS, auto immune disorder, other)? _____

_____

☐ Yes ☐ No Sensory issues (sensory processing disorder, autism, Asperger syndrome)?_____

_____

For Adolescent patients: Has patient entered puberty? ☐ Yes ☐ No If YES, approximate age? _____

DENTAL HISTORY (*please provide explanation for any "yes" answers)*

☐ Yes ☐ No Significant injury to teeth or jaws? _____

☐ Yes ☐ No Difficulty chewing? _____

☐ Yes ☐ No Grinding or clenching? _____

☐ Yes ☐ No Do you expect your child to have anxiety or be fearful about coming to the dentist/orthodontist? _____

_____

☐ Yes ☐ No Has your child had a traumatic dental experience? _____

_____

☐ Yes ☐ No Has your child previously had fillings or extractions? _____

_____

☐ Yes ☐ No Does your child brush? How often? _____

☐ Yes ☐ No Does someone help with brushing? _____

☐ Yes ☐ No Does your child floss? How often? _____

☐ Yes ☐ No Does your child use fluoridated toothpaste? _____

☐ Yes ☐ No Oral habits (thumb/finger sucking, nail biting, prolonged pacifier use, bottle, other)? _____

_____

☐ Yes ☐ No Speech disorders/therapy? _____

☐ Yes ☐ No Has patient had x-rays taken recently? _____

☐ Yes ☐ No Previous orthodontic exam? _____

☐ Yes ☐ No Smiles of Austin/Smiles of Dripping Springs is a dual practice providing expert pediatric dental care as well as orthodontic care for children and adults. Would you like more information about pediatric dentistry?

ADDITIONAL INFORMATION THE DOCTOR MIGHT FIND HELPFUL _____

_____

_____

_____

RELEASE AND WAIVER

The information I have provided regarding my child is accurate to the best of my knowledge, and I will notify my child's orthodontist of any changes in his/her 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 for my child 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 child's records transferred to a different orthodontist, there is a fee to obtain his/her records. I authorize the release of any pertinent information regarding my child's orthodontic treatment to his/her dental and/or medical insurance carrier.

_____ _____ _____

Signature Relationship 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.

_____ Unaccompanied Minors: When an unaccompanied minor comes for an appointment, the proper consent form(s) must be signed before the appointment and the child must be prepared to pay any payment due. We can take a credit card from the parent or guardian over the phone prior to the appointment. If another adult brings your child to the office (such as a grandparent or other family member), please provide them with any payment due.

_____ 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.

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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.

First Name _____ Last Name _____ Birthdate _____

Signature _____ Printed Name _____ Date _____