SMILES
AUSTIN | DRIPPING SPRINGS
Orthodontics and Pediatric Dentistry

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

PATIENT INFORMATION

Date _____

Patient Name _____ 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? _____ If a Child- What School_____

Is this the patient's first visit to a dentist? ☐ YES ☐ NO Dentist previously seen_____

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

_____

_____

RESPONSIBLE PARTY INFORMATION

Name _____

Birth date _____

Relationship to patient_____

Marital Status _____

Address _____

City _____ State _____ Zip_____

Home Phone _____ Cell _____

Email _____

Employer _____

SSN _____

Financially Responsible for Dental Services? ☐ Yes ☐ No

Name _____

Birth date _____

Relationship to patient_____

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 _____

SECONDARY DENTAL INSURANCE *(We do not bill medical insurance)*

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 Anxiety or fear about coming to the dentist? _____

_____

☐ Yes ☐ No Any traumatic dental experience? _____

_____

☐ Yes ☐ No Previous fillings or extractions? _____

_____

☐ Yes ☐ No If Child, does your child brush? How often? _____

☐ Yes ☐ No If Child, does someone help with brushing? _____

☐ Yes ☐ No If Child, does your child floss? How often? _____

☐ Yes ☐ No Does patient 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 either specialty?

ADDITIONAL INFORMATION THE DOCTOR MIGHT FIND HELPFUL _____

_____

_____

_____

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

***** I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the Smiles of Austin/Smiles of Dripping Springs doctors and staff to perform the necessary dental services my child may need, including any necessary life-saving procedures to be performed in the event of an emergency.***

I have been provided with a copy of this office's ***Notice of Health Information Privacy Practices.***

RESPONSIBLE PARTY NAME PRINTED_____

RESPONSIBLE PARTY 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.

_____ 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: _____

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please see the receptionist to request a copy.

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, Requests for restrictions on disclosures to your health plan for health care items or services paid out of pocket must be accepted..
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524 (paper or electronic).
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- receive a notice of a breach of "unsecured" protected health information

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information (PHI) we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose or sell your health information without your written authorization, except as described in this notice.

To Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at this office.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:

1. **Risk Management** - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

2. **Business Associates** - There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

3. **Notification** – We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

4. **Communication With Family** - Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

5. **Research** - We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

6. **Funeral Directors** – We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

7. **Organ Procurement Organizations** – Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

8. **Marketing** – We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

9. **Food and Drug Administration (FDA)** – We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement.

10. **Workers' Compensation** – We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

11. **Public Health** – As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

12. **Law Enforcement** – We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

13. **Schools**-We may disclose childhood immunization records to schools.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

This notice is effective as of ***March 2017*** *and will remain in effect until revised.*