Welcome Form

Your Name _____ **Phone** ( ) _____ ☐Cell ☐Home

Address _____ **City** _____

State_____ **Zip** _____ **E-mail** _____

Sex ☐Male ☐Female **Birthdate** _____/_____/_____ **SS#**_____-_____-_____

If Under 18, name of Parent / Legal Guardian _____ **SS#**_____-_____-_____

In case of emergency who should we call? _____ Phone for Emergencies Only ( ) _____

Who may we thank for referring you? _____

For your convenience, our practice sends appointment reminders and other important communications via text message to the phone number you specify above. Standard text messaging rates may apply. If you prefer to opt out, please check this box: ☐ Opt Out of Text Messaging

Do you have dental insurance? ☐Yes ☐No

Insurance 1:_____ ☐Primary ☐Dependent

Insurance 2:_____ ☐Primary ☐Dependent

Smile Survey

On a scale of 1 to 5, with 1 being "totally disagree" and 5 being "totally agree":

I'm happy with how my smile looks: _____ (scale of 1 to 5) Prefer Not to Answer ____

I'm getting dental care as regularly as I'd like to: _____ (scale of 1 to 5)

I'm interested in keeping my natural teeth for my whole life: _____ (scale of 1 to 5)

If there's one thing you'd like to improve about your smile, it would be:

☐Whiter Teeth ☐Other, please explain _____

☐Better Chewing Ability _____

☐Want Teeth to be Easier to Clean _____

☐I would change nothing, my smile is perfect!

NEW PATIENTS

Welcome to our practice, one of the finest and most advanced environments for oral health care. Our primary purpose is to serve you and your family and provide for your dental health needs in a considerate and caring fashion.

CANCELLATIONS/ MISSED APPOINTMENTS

We ask that you give 48 hours advanced notice for cancellation of appointments. **We will charge $65 per appointment hour for appointments cancelled or broken without 24 hours advance notice.**

Initial Please _____

PAYMENTS

Payment is expected the day of service rendered. In the event of a returned payment, or any balanced not covered by insurance that is over 60 days past due, your account will be turned over to our collections agency. You agree to reimburse Smile for Life Dentistry the fees of any collection agency, which will be added to the account at the time it is placed with an agency for collection and may be based on a percentage at a maximum of 35% of the debt, and all reasonable costs and expenses, including reasonable attorneys' fees, incurred in such collection efforts. For returned checks, there is a minimum $25 fee.

INSURANCE

If you have insurance, we will gladly process your forms. Our only request is that you pay your **estimated portion** when services are rendered. **Please remember that our contract for payment is with you and not your insurance carrier.** If you have provided us with your complete insurance information, we will be happy to bill your insurance as a courtesy to you. We allow 60 days from the date of service for payment from an insurance company. After this period you are responsible for payment of all unpaid fees.

CHILDREN

The dentist cannot treat children under the age of 18 years without a parent or legal guardian present.

FOR YOUR PROTECTION

This office has the most modern equipment, uses the most up to date techniques and above all, follows OSHA guidelines in advanced sterilization technology for both doctor and patient protection.

ELECTRONIC COMMUNICATION

You agree to occasionally receive personal protected health information via unencrypted email and/or text message unless written notice is provided to the office of your desire to opt-out.

Signature: _____ Date_____

Notice of Privacy Practices Summary

This describes how health data about you may be used and shared and how you can get access to this data.

I. How we may use health data about you:
   a. Treatment - We may use or share your health data to give you medical treatment or other types of health services.
   b. Payment - We may use or share your health data to bill you or a third party for payment for services provided to you.
   c. Health Care Operations - We may use and share health data about you for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
   a. To you
   b. As required by federal, state, or local law
   c. If child abuse or neglect is suspected
   d. Public Health risks for public health activities to prevent and control of disease.
   e. Lawsuits and disputes in response to a court or administrative order.
   f. Law enforcement to help law enforcement officials respond to criminal activities.
   g. Coroners, medical examiners, and funeral directors
   h. Organ or tissue donation facilities if you are an organ donor
   i. To avert a threat to individual or public health or safety

III. Disclosures where we have to give you a chance to agree or object:
   a. Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend or other person that you named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have these rights for the health data we keep about you:
   1. Right to inspect your health record and to receive a copy of your health record upon request.
   2. Right to amend information in your health record you believe is inaccurate or incomplete.
   3. Right to know to whom we have disclosed your health information.
   4. Right to ask for limits on the health information data we give out about you.
   5. Right to receive communication from us about your health information in alternate ways.
   6. Right to a paper copy of the complete Notice of Privacy Practices.

VI. You agree to occasionally receive health data via email and/or text message unless you choose to opt-out in writing.

I acknowledge that I have received the Notice of Privacy Practices of Smile for Life Dentistry.

Signature of Patient or Representative: _____

Print Patient Name: _____ Date:_____

Patient Birth Date: _____

Patient or patient's representative hereby consents to the sharing of my personal health information with the following individuals/entities (leave blank if none apply):

_____

_____

_____

_____