SMILE CENTER

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as possible. If you have any questions, we are glad to help.

Full Legal Name_____

Preferred Name_____

Gender:_____ **Marital Status:**_____**Birthdate:**_____

Cell Phone :_____ **Other:**_____

Email Address:_____

Address:

_____

_____

_____

Emergency Contact Information:

Name & Relationship:_____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulpha		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purposes of treatment, to obtain payment for treatment, and for healthcare operation.

Certain Circumstances

- Medical emergencies
- In situation required by law
- Individuals involved in your care
- When requested by public health agency

For any purpose other than treatment, obtaining payment, healthcare operation or certain circumstances, we will ask for your written authorization before using or disclosing your information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information in our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

**Conditions may apply; obtain additional information from that front desk.*

Changes To This Notice: We reserve this right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you.

SMILE CENTER

Acknowledgement of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

I, _____ (Patient), acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient's Signature Date

If the patient is a minor, a parent or legal guardian must sign.

_____

Parent or Legal Guardian Date

_____

Relationship to Patient

If the patient is not a minor, but under the care of a relative, friend, or caregiver, sign here.

_____

Signature Date

_____

Relationship to Patient

Delaware
1012 State Route 521
Suite 202
Delaware, OH 43015
740-417-9565

Linworth/Worthington
2245 W. Dublin Granville Rd
Suite 106
Worthington, OH 43085
614-350-7446

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1012 State Route 521
Delaware, OH 43015
Tel: 740-417-9565
Fax: 740-417-9571
www.smilecenterohio.com

DELAWARE SMILE CENTER

Financial Responsibility Form

Thank you for trusting your dental needs with Delaware Smile Center. To provide you with the best possible dental experience and to ensure we meet your expectations, please read and feel free to ask any questions before signing our financial responsibility form.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

You may feel that dental treatment is out of your reach. Please don't. We offer a variety of convenient payment options to make treatment available and affordable. We continue our commitment to you by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, and most credit cards. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment options. A $35 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

We will communicate all recommended treatment options and associated fees prior to the start of treatment. 20% of the patient responsibility will be expected when scheduling your treatment appointments, with the remaining treatment balance due at the time of service. A 5% treatment discount is available for balances paid in full in advance for cash pay patients. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist in receiving the dental benefits. We require that any applicable deductibles and estimated patient portions be paid at the time treatment is rendered. We are participating providers in most major PPO dental insurance plans. Knowing your dental insurance benefits is your responsibility; however, we will do our best to provide you with as much information as possible. Insurance plans vary from covered services to benefits paid and even yearly maximums. We will make every effort to provide as much information regarding your coverage as we are able, however, as the dental care provider our relationship is with you and not the insurance company. We will also do our very best to estimate your portion for dental services, but remember it is only an ESTIMATE.

If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

I have read the above financial policy and acknowledge and agree it is my responsibility to pay the balance for services incurred. I understand that I am responsible for any additional patient balances due once insurance benefits have been received. I acknowledge that I am responsible for any charges refused or discontinued by my insurance company. Further, I will pay for any collections or legal charges incurred in the collection of these uncovered charges should I fail to pay them during the agreed upon time.

Printed Name_____ Date _____

Signed _____ Witnessed _____

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Delaware, OH 43015
Tel: 740-417-9585
Fax: 740-417-9571
www.smilecenterohio.com

DELAWARE SMILE CENTER

Late and Cancellation Policy

Thank you for trusting your dental needs with the Delaware Smile Center!

We understand the occasional need to reschedule or move appointments. As a courtesy, we ask that you provide us with at least **24hr prior notice to your scheduled appointment with our hygiene department**, and at least **48hr prior notice with our restorative department**. We ask that you provide us with at least **72hr prior notice for any appointment involving IV Sedation.** In order to cancel or reschedule an appointment we ask that you speak with a member of our team directly. Messages left, emails, and text messages will not be accepted as a method of cancellation.

Attending your dental appointment on time is important to serving your dental needs. We need the appropriate time to perform dental procedures so that your experience is comfortable and pleasant. As a patient, you are our focus during your scheduled appointment time, and we will respect your appointment time. As we do not double-book our schedule, it is important to our other patients that their appointment times be respected as well.

It is for that reason; **all late or broken appointments are subject to a non-refundable late fee. Late or broken appointments with the hygiene department will incur a $25 fee. Late or broken appointments with the restorative department will incur a $50 fee. Late is considered 15 minutes after the scheduled visit time. Broken is considered providing less than the required notice when canceling or rescheduling an appointment.**

In very rare occurrences, if a patient's attendance becomes an issue, we reserve the right to dismiss chronically late patients from the practice.

These policies and agreements are here to ensure you receive the best possible treatment. If you have any questions regarding the policy, please don't hesitate to ask.

I _____ hereby acknowledge that I will be charged a fee of $25 for a late or missed hygiene appointment and/or be charged a fee of $50 for a late or missed restorative appointment. An appointment is considered late if the patient arrives more than 15 minutes after the scheduled visit time. A missed appointment charge also occurs when the patient provides less than a 24hr notice prior to a scheduled hygiene visit, a 48hr notice prior to a scheduled restorative visit, and a 72hr notice prior to any appointment involving IV Sedation. Late and broken appointment fees must be paid in full before any appointment can be rescheduled.

Signed _____ Date _____

Witnessed _____ Date _____