





**All About Smiles Family Dentistry**

***Patient Information Form***

**Health Information**

Date of Last Dental Visit: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

Have you ever had any of the following? Please circle those that apply:

AIDS Venereal Disease Artificial Joints Rheumatism Arthritis Glaucoma  
Stomach/Digestive Problems Ulcers Acid Reflux Syndrome Hay Fever  
Respiratory Problems Asthma Sinus Problems Tuberculosis Tumors Growths  
Cancer Chemotherapy Radiation Treatment Excessive Bleeding Blood Disorder  
Anemia Dizziness Nervous Disorder Head Injuries Mental Disorders Epilepsy  
Kidney Disease Diabetes Thyroid Problems Jaundice Liver Disease Hepatitis

Pregnant? Due: \_\_\_\_\_

Mitral Valve Prolapse Rheumatic Fever Heart Murmur High Blood Pressure  
Stroke Heart Disease Pacemaker

OTHER MEDICAL CONDITIONS: \_\_\_\_\_

Penicillin Allergy Latex Allergy Codeine Allergy

ANY ALLERGY: \_\_\_\_\_

CURRENT MEDICATIONS:

\_\_\_\_\_

Have you ever had any complications following dental treatment? Yes No

If yes, please explain:

\_\_\_\_\_

Are you now under the care of a physician? Yes No

If yes, please explain:

\_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any health problems that need further clarification? Yes No

If yes, please explain:

\_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct.  
If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

\_\_\_\_\_

Signature of patient, parent or guardian Date

\_\_\_\_\_

Signature of reviewing doctor Date





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**Referral Information**

Whom may we thank for referring you to our practice?

Another patient, friend    Another patient, relative    Another Doctor's Office  
Phonebook    Newspaper    School Work Website    Other\_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

**Spouse or Responsible Party Information**

The following is for:    the patient's spouse    the person responsible for payment

Name: \_\_\_\_\_

Male    Female    Married    Single    Divorced    Widowed    Child    Other

Social Security #: \_\_\_\_\_    Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell)\_\_\_\_\_

Best time to call: \_\_\_\_\_    Best number to call: \_\_\_\_\_

Address:

\_\_\_\_\_ Street    Apartment #

\_\_\_\_\_ City    State    Zip Code

Account will be paid by: \_\_\_CASH    \_\_\_CHECK  
   \_\_\_ Visa/MasterCard/Discover/American Express

**PLEASE NOTE: ALL CHARGES DUE AT TIME OF SERVICE.**

If insurance in effect, please let us know prior to treatment.

What is your e-mail address? \_\_\_\_\_

Would you like us to confirm your appointments by email?    Yes    No





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**Employment Information**

The following is for: the patient the person responsible for payment

How long employed? \_\_\_\_\_

Employer Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address:

\_\_\_\_\_ Street Apartment #

\_\_\_\_\_ City State Zip Code

**Insurance Information**

*Primary Insurance*

Name of Insured: \_\_\_\_\_  
Last First MI

Is insured a patient? Yes No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_  
Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name and Address \_\_\_\_\_

\_\_\_\_\_ Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

\_\_\_\_\_ Street City State Zip Code







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**Consent for Services**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company .Any fees not paid by a patient's insurance carrier within 90 days of service become the responsibility of the patient to pay at that time.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

INSURANCE AUTHORIZATION/ASSIGNMENT: I hereby authorize the doctor to furnish information to insurance carriers concerning my treatments and I hereby assign to the dentist all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. I further agree to pay all costs and reasonable attorney fees that are incurred in attempts to collect any unpaid balance.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature of patient, parent or guardian

Relationship to Patient: \_\_\_\_\_



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## What is the HIPAA Privacy Rule?

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. It is a federal law under which the Secretary of the U.S. Health and Human Services issued regulations that give patients protections over the privacy of their dental records.

The final privacy regulation took effect April 14, 2003. It balances strong privacy protections against efficiency and access to quality health care. Patients are guaranteed access to their dental records; given more control over how their protected health information is used and disclosed; and are allowed to file complaints if their medical privacy is breached. The privacy rule protects medical records and other personal health information maintained by certain dentists, physicians, hospitals, health plans, health insurers and health-care clearinghouses.

Under the privacy rule, this dental practice:

- ▼ Must get your specific authorization before we may use or disclose your protected information in non-routine circumstances, such as releasing information to an employer or for use in marketing activities.
- ▼ Will allow you to request an account of non-routine uses and disclosures of your health information.
- ▼ Will provide you with written notice of our privacy practices and your privacy rights. Patients will generally be asked to sign, or otherwise acknowledge receipt of, the privacy notice from direct treatment providers such as dentists.
- ▼ May communicate freely with you about treatment options and with other health-care providers involved in your care.
- ▼ Will allow you to access your personal dental records and request changes to correct any errors.

The privacy rule, established as part of the federal privacy act, enhances protections under existing Florida law. Our dental practice adheres to Florida laws *and* federal laws that protect your health information. Our policies apply to all patients in this dental practice, whether they are privately insured, uninsured or covered under public programs such as Medicare or Medicaid.

We care about your oral health and are here to help you. If you have questions about how the HIPAA privacy regulation relates to your dental care, please feel free to contact our office.

*The Florida Dental Association is pleased to provide this information on the HIPAA Privacy Rule as a public service.*





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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

(Note: The previous page is the HIPAA notification. The complete Notice of Privacy Practices for our office is available at the bottom of the website or at the reception desk in our office.)

*You May Refuse to Sign This Acknowledgment*

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for ALL ABOUT SMILES FAMILY DENTISTRY this \_\_\_ day of \_\_\_\_\_, 20\_\_\_. A copy of this signed, dated Acknowledgement shall be as effective as the original.

\_\_\_\_\_  
Please print your name

\_\_\_\_\_  
Please sign your name

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority \_\_\_\_\_.

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Shelia Hopfensperger.

**Office Use Only**

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

- It was emergency treatment \_\_\_\_\_
- I could not communicate with the patient \_\_\_\_\_
- The patient refused to sign \_\_\_\_\_
- The patient was unable to sign because \_\_\_\_\_
- Other (please describe) \_\_\_\_\_

\_\_\_\_\_  
Signature of privacy officer