ELITE SMILE
FAMILY DENTISTRY

Date _____How were you referred to our office?_____

Patient Information Sheet

Name:_____ Male/Female Date of Birth:_____Age_____

Address: _____City:_____State: _____Zip Code:_____

Home #:_____ Cell #:_____ Work #:_____

Primary Phone #:_____

Social Security #:_____

Email :_____

Guardian Information/Spouse Information

Guardian/Spouse Name: _____Date of Birth: _____

Address:_____City: _____State:_____Zip Code:_____

Home #:_____ Cell #:_____ Work #:_____

Insurance Information

Insurance is billed as a courtesy to our patients. Patient copayment serves as estimate only. You will be responsible for all treatment fees not paid by your insurance company.

Please initial_____

Primary Subscriber Name: _____Date of Birth:_____

ID #:_____ SS #:_____

Insurance company name:_____ Phone #:_____

Group Number:_____

Secondary Subscriber Name:_____Date of Birth:_____

ID #:_____ SS #:_____

Insurance company name:_____ Phone #:_____

Group Number:_____

Patient/Guardian Signature:_____Date:_____

Are your teeth sensitive to:

Hot? Yes No
Cold? Yes No
Sweets? Yes No
Biting Pressure? Yes No

Does food get caught between your teeth? Yes No Do your gums bleed when brushing? Yes No

Do you have swelling? Yes No

Do you notice bad mouth odor? Yes No

Problems with your jaw: Yes No

Difficulty opening or closing? Yes No
Difficulty chewing? Yes No

Are you dissatisfied with the appearance Of your teeth? Yes No

Do you smoke? Yes No

Do you have missing teeth? Yes No

Do you want to lose any teeth? Yes No Do you have any fears of having Dental Work? Yes No If so, explain:_____

_____

Will you need a payment plan to cover Your expenses? Yes No

Do you have frequent headaches? Yes No

Do you snore? Yes No

Have you been diagnosed with sleep apnea? Yes No Do you have crowding or spacing in teeth? Yes No

Have you been diagnosed with HPV? Yes No Do you have a latex allergy or sensitivity? Yes No

When was your last dental appointment?_____

_____

Do you have any general health problems? Yes No If so, please specify:_____

_____

_ Have you had surgery? Yes No If so, explain:_____

_____

Are you currently under a physician's care? Yes No If so, explain:_____

_____

Any Medications? Yes No

If so, please list:_____

_____

Do you have any allergy? Yes No If so, please list:_____

_____

To the best of your knowledge, do you or your family members have the following medical conditions?

Heart Disease Yes No me / family
Pacemaker Yes No me / family
Diabetes Yes No me / family
Artificial joint Yes No me / family
Rheumatic Fever Yes No me / family
Kidney disease Yes No me / family
Cancer Yes No me / family
Epilepsy Yes No me / family
High Blood Pressure Yes No me / family
Respiratory Disease Yes No me / family
Hepatitis Yes No me / family
HIV Positive Yes No me /family
Prolonged Bleeding Yes No me/family

Are you pregnant Yes No

Patient/Guardian Signature:_____Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCOLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice, effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices. We will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFOMRATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures of your health information. We will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health of safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format your re quest unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0-50 for each page. $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format we will charge a cost-based fee for providing your health information in that format if you prefer we will prepare a summary or an explanation of your health information for a fee.
Contact us using the information sheet at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: you have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation on how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or t have use communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer_____

Telephone_____ Fax_____

E-mail_____

Address_____

ACKNOLWEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Elite Smile Family Dentistry

PLEASE SIGN THE FORM BELOW UNDER THE HEADING CONSENT OT CONSENT TO OUR DISCLOSURES OF YOUR INFOMRATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PART ONE: **Acknowledgement of Receipt of Privacy Notices**

I,_____, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature:_____**Date:**_____

If a personal representative signs this authorization on behalf or the individual please complete the following.

Personal Representative's Name:_____

Relationship to Individual: _____

FOR OFFICE USE ONLY:

PART TWO: Good faith effort to obtain acknowledgement of Receipt

Patient refused to sign:

Describe your good faith effort to obtain the individual's signature on the form: _____

_____

Describe the reason why the individual would not sign the form: _____

_____

PATIEINT CONSENT

I attest that the above information is correct.

Patient Signature:_____Date:_____

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. However, due to many changes in insurance policies, it is no longer an easy task to interpret each individual's policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company prior to any office procedures. We charge what is reasonable and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Also, understand that not all service areas covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit. Please remember that your insurance policy is between you and your insurance company and your insurance company and your doctor.

Payments for services are due at the time services are rendered unless our staff has approved payment arrangements. We accept cash, check, Discover, MasterCard or Visa and offer financing through credit companies.

We realize that temporary financial problems my affect timely payment of your account. If such problems arise, we encourage your contact to us promptly for assistance in the management of your account.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

Initial_____

I consent to treatment by Dr. Tosha Patel D.M.D and team for myself and/or minor child. I have been provided the practice's statement regarding use and disclosure of my protected health information. I understand I may have a copy of this statement if I request if from the practice's privacy officer.

I authorize the release of any information necessary to process my claims and authorize payment to Dr. Tosha Patel D.M.D

Your signature below verifies that you have read and understand this statement, and that all your questions have been answered.

Signature_____ Date_____

Broken Appointment Charge Policy

In our best efforts to see all emergencies on the same day please confirm your visit 24 hours prior.

We do understand that you may have emergencies such as an illness the same day of your appointment and will consider each individual circumstance before adding this charge to your account.

We will attempt to reach you many times using all the contact information we have available. In the event we are unable to reach you, your appointment may be cancelled, so do be sure we have good contact information.

Cancellation in less than 24 hours or No Show-No Call fees: $25

I have read and understand this cancelation and No Show-No Call Policy

_____ _____

Patient Signature Date

HIPAA Authorization to Release and Discuss Dental and Billing Information

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance companies and previous companies, unless we have your authorization in writing to communicate with others on your behalf.

HIPAA law states that if you are 18 years old or above, we cannot speak to ANYONE about billing or treatment without your written consent and this limitation includes: parents of plus 18 and spouses. So, it is important you carefully list each person you give us authorization to communicate with on your behalf. If you would like to give us the authorization to communicate with another person or party on your behalf, please fill out and sign the form completely.

If you may opt out by checking the "DO NOT RELEASE INFORMATION" box below.

Authorization to Communicate Treatment and Billing Information:

I give the following person(s) authorization to take messages or speak on my behalf to Elite Smile Family Dentistry and team members.

Name of authorized person(s):

Name: _____ Relationship: _____

Phone: _____

☐ Appointments ☐ Financial ☐ Treatment ☐ Insurance ☐ Other

Name: _____ Relationship: _____

Phone: _____

☐ Appointments ☐ Financial ☐ Treatment ☐ Insurance ☐ Other

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**I authorize Elite smile Family Dentistry and Team to leave messages, emails and voicemails regarding treatment and billing by:*

☐ *Home* ☐ ☐ *Work* ☐ ☐ *Cell* *Text* *E-Mail*

_____ DO NOT RELEASE MY INFORMATION TO ANYONE

I understand that my express consent is required to release any health or financial information.

My signature below acknowledges my understanding that all my information will be kept secure and above listed parameters will remain in effect until revoked by me in writing. It will be my responsibility to notify Elite smile Family Dentistry and team should I wish to change this authorization.

Parents/Guardians Signature: _____ **Date:** _____