PATIENT REGISTRATION

ID: _____

Patient is : ○ Responsible Party ○ Policy Holder

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Name of Guardian if patient is a minor: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Sex: ○ Female ○ Male Birth date: _____ Social Security #: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Insurance Information:

Dental Coverage? ○ **Yes** ○ **No** **Medical Coverage?** ○ **Yes** ○ **No**

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Employer: _____ Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Insurance Company: _____ Insurance Company #: _____

Patient Dental History:

Name of Previous Dentist: _____ Phone #: _____

Date of last dental visit: _____ Date of last cleaning: _____ Date of last X-rays: _____

Preferred pharmacy: _____ Phone #: _____

Patient Questionnaire:

○ Yes ○ No Do your gums bleed while brushing or flossing?

○ Yes ○ No Are you currently feeling any pain on any tooth?

○ Yes ○ No Do you have any sores or lumps in or near your mouth?

○ Yes ○ No Are you happy with the way your smile looks?

If not, what would you change? _____

○ Yes ○ No Have you had any orthodontic work?

○ Yes ○ No Have you ever had any difficult extractions in the past?

○ Yes ○ No Have you ever had prolonged bleeding following extractions?

○ Yes ○ No Do you still have your wisdom teeth?

○ Yes ○ No Would you like whiter teeth?

Reason for todays visit: _____

How did you hear about us?

○ Referred By: _____ ○ School Letter ○ Apartment Flyer ○ Referral by Medical Group/Insurance

○ Event / Fair ○ Internet ○ Facebook ○ Mail ○ TV / Radio ○ Driving by

Dental Claim Agreements

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted under applicable law, I authorize release of any information relating to any dental claims. I hereby authorize payment of the dental benefits otherwise payable to me directly to SMILEY DENTAL.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	
Do you need to pre-medicate?	◯ Yes ◯ No	If yes, please explain: _____

Women: Are you?

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics

◯ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No		◯ ◯

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Oral Health Questionnaire

Child's Name_____ **Date**_____

Child's Age _____ **Child's Date of Birth** _____

HEALTH HISTORY	**Yes**	**No**
Did the birth mother have any problems during pregnancy?	☐	☐
Was your child premature?	☐	☐
Was your child's birth weight low?	☐	☐
Were there any complications at birth?	☐	☐
Has your child been ill?	☐	☐
Is your child on any medications?	☐	☐
DIET AND NUTRITION		
Is/was your child breastfed?	☐	☐
Does your child sleep with a bottle?	☐	☐
Does your child drink from a cup?	☐	☐
Does your child walk around drinking from a bottle or cup?	☐	☐
Is your child on a special diet?	☐	☐
How many times does your child snack each day? _____		
How many bottles does your child have each day? _____		
FLUORIDE ADEQUACY		
Do you know the fluoride level of your water?	☐	☐
Do you have well water?	☐	☐
Do you use bottled water?	☐	☐
Do you use a water conditioner or filtration system?	☐	☐
If yes, please list _____		
Do you use fluoride toothpaste for your child?	☐	☐
ORAL HABITS		
Does your child use a pacifier?	☐	☐
Does your child suck a thumb or fingers?	☐	☐
Does your child grind his/her teeth day or night?	☐	☐
INJURY PREVENTION		
Is your child walking?	☐	☐
Is your home childproofed?	☐	☐
Do you use a car seat for your child?	☐	☐
Has your child had an injury to his/her mouth or face?	☐	☐
ORAL DEVELOPMENT		
Does your child have any teeth?	☐	☐
Child's age (in months) when the first tooth came in? _____		
Has your child had teething problems?	☐	☐
Have you noticed any problems with your child's mouth or teeth?	☐	☐
Does your child complain of mouth pain?	☐	☐
Have any of your children ever had cavities?	☐	☐
Have you or your children ever had a bad dental experience?	☐	☐
ORAL HYGIENE		
Do you clean your child's gums/teeth?	☐	☐
Do you use a toothbrush to clean your child's teeth?	☐	☐
Do you use toothpaste to clean your child's teeth?	☐	☐

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See **http://www.dshs.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

NOTICE OF PRIVACY PRACTICES

Smiley Dental

Privacy Officer: Ruby Reyna

Effective Date: 02/01/2017

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical/ dental information. We make a record of the dental care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality dental care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this dental practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical/ dental information. It also describes your rights and our legal obligations with respect to your medical/ dental information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Dental Practice May Use or Disclose Your Health Information

This dental practice collects health information about you and stores it in a chart [and/or on a computer][and in an electronic health record/personal health record]. This is your dental record. The dental record is the property of this dental practice, but the information in the dental record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical/ dental information about you to provide your dental care. We disclose medical/ dental information to our employees and others who are involved in providing the care you need. For example, we may share your medical/ dental information with other dentists or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical/ dental information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical/ dental information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical/ dental information about you to operate this dental practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your dental plan to authorize services or referrals. We may also use and disclose this information as necessary for dental reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical/ dental information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or dental plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical/ dental information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine

or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical/ dental information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical/ dental information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying

or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we may be required make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this dental practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another dentist or dental group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Dental Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this dental practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this dental practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical/ dental information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also

send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this dental practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this dental practice, except that this dental practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this dental practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this dental practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region VI - Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Jorge Lozano, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf

You will not be penalized in any way for filing a complaint.

FACTS YOU SHOULD KNOW ABOUT DENTAL INSURANCE

Dental Insurance is rapidly playing a large role in helping people obtain dental treatment. Since we STRONGLY feel our patients deserve the best possible dental care we can provide and in an effort to maintain the high quality of care, we would like to share some facts about dental insurance with you. Our office staff understands dental insurance and we will be glad to assist you in obtaining the maximum benefits specified in your dental insurance plan.

Fact #1: Your dental benefit program is contract between you, your employee, and the insurance company. **WE ARE NOT PART OF THAT CONTRACT.**

Fact #2: Dental insurance is **NOT** meant to be a **PAY-ALL**, only to be and aid.

Fact #3: Our fees are generally, but not necessary, covered in full by the maximum allowance. Determine by you carrier. Many plants tell their insured that they will be covered "up to 80% or up to 100%", but do not clearly specify the plans fee scheduled allowance, annual maximum or limitations. We have found that most plans cover about "35% to 50%" on major services (crowns, bridges, root canals) base on the plan's pre-established maximum fee allowance which varies from carrier to carrier.

Fact #4: It has been the experience of .many Dentists that insurance companies occasionally tell their insured that "the fees charged were above usual and customary rate", rather than saying" their benefits are low."

Fact #5: Many routine dental services **ARE NOT** covered by insurance carries. For example: Nitrous Oxide (Laughing Gas)

Fact #6: You, the patient are ultimately responsible to us for ALL FEES for service rendered.

IF YOU FAIL TO GIVE OUR OFFICE AT LEAST 24 HOUR NOTICE OF CANCELLATION, YOU WILL BE CHARGED A BROKEN APPOINTMENT FEE OF $25.00. ·FULL PAMENT IS EXPECTED AT THE TIME OF YOUR VISIT.

If your insurance company has not paid on your claim within 30 Days of Services rendered then it is **YOUR REPSONSIBILITY** to check to see why the claim has not been paid and your balance is due in full. Our office stall will be glad to assist you in any way they can regarding your insurance claim payments.

Please do not hesitate to ask questions about our office policy. We want you be comfortable in dealing with these .matters and we urge you to consult us regarding our services and /or fee. We are here to answer any questions you may have about your insurance or any dental treatments.

_____	_____	_____
Patient's name (please print)	Signature of patient, legal guardian or authorized signature	Date

Smiley Dental & Orthodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may Refuse to Sign This Acknowledgement

_____ _____

Print Patient's Name Date

I, _____ (patient or parent/legal guardian), acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, _____ (patient or parent/legal guardian), consent to use and disclosure of my personal health information by your office for treatment, billing/payment, and healthcare operations as outlined in the NOTICE OF PRIVACY PRACTICES.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

☐ Individual refused to sign

Witness Print Name and Sign: _____ Date: _____

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify): _____