RenovaSmiles
FAMILY & COSMETIC DENTISTRY

Welcome

To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please ask someone at the front desk and we will be happy to help you.
Thank you for being our patient!

PATIENT INFORMATION

Name (First / Last / MI)

Preferred Name

Gender: Male / Female / Child

SSN

Date Of Birth (M M D D Y Y Y Y)

Address

City

Zip code

State

Cell Number

Work Number

Home Number

E-Mail

Emergency Contact

Emergency contact phone Number

INSURANCE INFORMATION

Policy holder's name

Insured's SSN

Policy DOB (M M D D Y Y Y Y)

Insured's Relationship to Patient

Insurance Company

Employer

Group #

Is the patient covered by additional insurance? Yes / No

Phone

Details

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship to Patient

Date: (M M D D Y Y)

DENTAL HISTORY

Please mark with a **X** if you have one of these symptoms:

Reason for today's visit _____

_____

Former Dentist _____

Phone _____

Date of last dental exam _____

Date of last dental xrays _____

Date of last cleaning _____

How often do you brush? _____

How often do you floss _____

Do you feel pain anywhere? _____

Describe _____

_____

Sensitivity to hot/cold	◯	Bad breath	◯
Sensitivity to sweet	◯	Burning sensation on tongue	◯
Avoid one side of the mouth when chewing	◯	Dry Mouth	◯
Sensitivity when biting	◯	Accident involving jaw	◯
Broken/cracked tooth	◯	Clicking or popping jaw	◯
Food collection between teeth	◯	Frequent headaches	◯
Tobacco use	◯	Grinding teeth	◯
Gums swollen or tender	◯	Jaw pain or tiredness	◯
Gums bleed frequently	◯	Pain around ear	◯
Orthodontic treatment	◯	Periodontal treatment	◯

MEDICAL HEALTH HISTORY

Allergies? :

Aspirin	Erythromycin	Tetracyline	Codeine	Latex	Penicillin
Y N	Y N	Y N	Y N	Y N	Y N

Please list others:

Physician Name _____

Phone _____

Please list all current medications (include prescriptions, over-the-counter, herbal supplements) and reason for use

_____

Please mark with **X** if you have any:

- ◯ AIDS/HIV
- ◯ Anemia
- ◯ Arthritis
- ◯ Respiratory problems
- ◯ Blood transfusion (Date:_____)
- ◯ Cancer
- ◯ Cardiac pacemaker
- ◯ Artificial joint/valve
- ◯ Convulsions/Epilepsy/Seizures
- ◯ Diabetes
- ◯ Excessive bleeding w/surgery
- ◯ Heart problems: _____
- ◯ Liver problems
- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Kidney problems
- ◯ Radiation/Chemotherapy treatment
- ◯ Tuberculosis
- ◯ Stroke
- ◯ Thyroid disorder
- ◯ Heart murmur
- ◯ Mitral valve prolapse
- ◯ Rheumatic fever
- ◯ Other

Women Only: Are you pregnant? Y N Are you nursing? Y N Do you use birth control? Y N

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

Responsible Party Signature

Date: D D M M Y Y

Attending Dentist Signature

Date: M M D D Y Y

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PAYMENT AND CANCELLATION POLICY

Payment at the time of services is expected. For your convenience, we take cash, credit, debit or Care Credit. Our office will be happy to submit claims to your insurance company. A service charge of 1-1.5% per month will be added to all balances 60 days and older. The annual rate of the service charges is 18%. I understand that RenovaSmiles will make every effort to collect from my insurance company. I hereby authorize RenovaSmiles to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered covered by insurance for services rendered to me or my dependents. I also acknowledge and understand that if the account is turned over to an attorney for collection, I hereby agree to pay thirty percent (30%) attorney or collection agency fees on the unpaid balance.

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointment times at RenovaSmiles are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.
In an effort to decrease unnecessary waste related to staffing, supplies and to be able to continue providing you and your family with exceptional dental services, we maintain a No-Show/Cancellation Policy for all of our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or is unable to be kept, must be cancelled at least 24 hours in advance of the appointment. Cancellations must be made during normal business hours on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the phone by speaking directly to one of our dental professionals or via our email. Patients will not be charged if cancellation is made at a minimum of 24 business hours before their appointment.

Since we certainly understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than 24 hours notice, or no notice, a $50 charge will be billed. If a third no-show or same day cancellation occurs, we reserve the right to terminate the doctor-patient relationship as well as another $50 charge.

This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

The undersigned hereby authorizes the release or any information relating to all claims for benefits submitted on behalf of myself, spouse, or dependents including the assignment of benefits payable to RenovaSmiles. I further agree and acknowledge that my signature on this document authorizes my dentist to submit for myself, spouse, or dependents all insurance claim forms necessary for submission and that I will be bound by this signature as though the undersigned had personally signed the particular claim form.

Past due balances are subject to a late payment of 1-1.5% per month (18% annual).

Responsible Party Signature: _____

Relationship to Patient: _____ **Date:** M M D D Y Y

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NOTICE OF HIPAA PRIVACY LAW

This notice describes how health information about you may be used and disclosed on how you can get access to this information. Please review it carefully.

How your HEALTH INFORMATION may be used:

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you with treatment.

To Obtain Payment

We may use and disclose your health information to obtain payment for services you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically.

To Conduct Health Care Operations

We may use and disclose you 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 provider performance, conducting training programs, accreditation certification, licensing or credentialing activities.

In Patient Reminders

We will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. They may include postcard, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We may disclose your health information to appropriate authorities if we 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 or safety of others.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete and investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

Required By Law

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

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. In the event or your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only heath information that is directly relevant to the person's involvement in your healthcare, we will also use 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 Studies

We will not use your health information for marketing communications without your written authorization.

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.

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 written authorization, we cannot disclose your health information for any reason except those described in this notice.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

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).

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.

Confidential Communications

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

Documentation of Health Information

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 account more than once in a 12 month period, we may charge you a reasonable, cost –based fee for responding to these additional requests.

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NOTICE OF HIPAA PRIVACY LAW

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 you request 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 may charge 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 listed at the end of this notice for full explanation of our fee structure.)

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail it to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of revised Notice.
You have the right to express complaints to us or the Secretary of Heath and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by Contacting: Office Manager.

Patient acknowledgement

Purpose of Consent

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you if you revoke this consent.
I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Pint Name: _____

Signature: _____

Date: M M D D Y Y

If this consent is signed by a Minor or personal representative on behalf of the patient, complete the following

Personal Representative Name _____

Relationship with patient: _____

The following is OPTIONAL: Consent for an Individual, such as spouse or any family member

Permission for Consent:

I _____
(Your name)

give _____
(Name or Names of Individuals)

Permission to discuss my dental account which includes treatment, balances, appointments, etc. with Renovasmiles and it's employees; unless I notify you otherwise.

Print name _____

Signature: _____

Date: M M D D Y Y