SMARTEETH DENTAL

1973 Foothill Parkway, Suite 102 Corona, CA 92881
(951) 256-4556

www.coronasmarteethdental.com

Patient Name _____
LAST FIRST MIDDLE INITIAL

Gender [ ] Male [ ] Female **Marital Status** [ ] Married [ ] Single [ ] Child [ ] Other: _____

Social Security # _____ **Date of Birth** _____
DD / MM / YY

Address _____

City _____ **State** _____ **Zip Code** _____

Phone (Cell #1) _____ **(Alternative #)** _____

Emergency Contact# / Relation _____

Employer _____ **Primary Language** _____

Email _____

MEDICAL HISTORY

Reason for Visit/Area of Concern _____

Date of Last Dental Visit _____

1. Have you ever been prescribed a BLOOD THINNER or BONE DENSITY Medication? (Fosamax / Plavix / Coumadin / Aspirin)	YES / NO
2. Are you ALLERGIC? Aspirin / Penicillin / Codeine / Latex / Local Anesthetic / Other: _____	YES / NO
3. Have you ever had any complications following dental treatment? If YES, explain: _____	YES / NO
4. Have you been admitted to the hospital or needed emergency care in the past two years? Explain: _____	YES / NO
5. Are you under the care of a physician now? If YES, explain: _____ Name of Physician: _____ Office Name: _____ Phone #: _____	YES / NO
6. Do you have any HEART PROBLEMS If YES, explain: _____	YES / NO
7. Have you ever been told to take antibiotics prior to dental treatment? If YES, explain: _____	YES / NO
8. FEMALES-Are you or could be PREGNANT at this time? If YES, DUE DATE: _____ Trimester: 1st / 2nd / 3rd	YES / NO

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Please check ALL the apply

[ ] **NONE**	[ ] Dizziness	[ ] Hepatitis A/B/C	[ ] Rheumatism
[ ] Aids	[ ] Epilepsy	[ ] Jaundice	[ ] Sinus Problems
[ ] Allergies: _____	[ ] Excessive Bleeding	[ ] Kidney Disease	[ ] Stomach Problems
_____	[ ] Fainting	[ ] Liver Disease	[ ] Stroke
[ ] Anemia	[ ] Glaucoma	[ ] Mental Disorders	[ ] Tobacco Use
[ ] Asthma	[ ] Growths	[ ] Nervous Disorders	[ ] Tuberculosis
[ ] Blood Disease	[ ] Heart Murmur	[ ] Pacemaker	[ ] Tumors
[ ] Cancer	[ ] Hay Fever	[ ] Radiation Treatment	[ ] Ulcers
[ ] Diabetes(Type I / Type II)	[ ] High/Low Blood Pressure	[ ] Respiratory Problems	[ ] OTHER:

Are you currently taking any medications? **[ ] None [ ] Yes**

If **YES**, please list the name(s) and dosage(s): _____

_____

_____

_____

_____

_____

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

Signature of Patient **Date**

(If patient is a minor, Parent or Guardian)

Provider's Signature

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Financial Policy of SMARTEETH DENTAL

We are committed to providing you with the best possible care. As a professional courtesy, if you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policies.

_____ Initials – **Payment is due at the time of service, including any deductibles or co-payments.** We accept the following forms of payment:

1. **Cash**
2. **Credit Card - Master Card/ Visa/American Express/ Discover**
3. **Care Credit** - offers a separate line of credit to cover your entire family's health care needs. (Please ask the office staff for more information)

_____ Initials – **Accounts with a balance over 60 days** will be turned over to Cornerstone Collection Agency. We have a payment plan option through Care Credit if you wish to make use of this. Once an account has been referred for collection, the doctor-patient relationship is considered terminated. Your records will be referred to a dentist of your choice.

_____ Initials – **Insurance Billing**

You are expected to alert us in full disclosure of all of your dental insurance plans. We will contact your insurance company for you to inquire about your eligibility and benefits, therefore, we will need all of your insurance information at your initial visit. We will work to the best of our ability to accommodate your needs and provide you with the options allowed by your insurance, will inform you of the co-pay, and any other costs that are associated with your appointment before we begin your treatment; with the following stipulations:

- **You are expected to pay in full your co-pay upfront. We will calculate your total for you and present you with cost breakdowns. You will be made aware of any additional payment required for treatment beforehand.**
- **Ultimately the balance of your account is your responsibility. While we will do our best to obtain accurate information regarding your eligibility and benefits, in rare cases the insurance companies will not always provide us with the most up to date information resulting in inaccuracies. In this scenario we will require you to pay the remaining balance. Your insurance policy is strictly between you and your insurance company, we are not privy to it. We do offer Care Credit as a payment plan option; please feel free to ask any of our staff how to apply.**
- **We will allow a 60 day period in which you can pay the remaining balance after we have informed you that it is due. If you do not pay in the allotted time your account will be considered overdue.**

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance.

Signature of Patient _____ Date _____

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NOTICE OF PRIVACY PRACTICES
(Please Read carefully and Take this with you)

Under the Health Insurance Portability and Accountability Act of 2013 (HIPAA) we are required to inform you of our privacy policy. We use the personal and health information you provide us to assess your condition and provide treatment within our office. Only the doctor and employees have access to your personal and health information. Your information will not be released to outside parties without your consent or for non-medically related purposes.

We may provide your information to Insurance Plans, 3rd Party Billing Services, or Direct Reimbursement Plans for payment. We may provide your information to collection services. We may provide your information to pharmacies for drug prescription services. We may provide your information to health care providers for consultation purposes, or referrals. If you pay 100% out of pocket you have the right to request that your information not be released to your health plan unless it is necessary for treatment purposes or required by law.

You have a right to a written copy of our privacy policy. You have a right to see, amend, and get copies of your records. You have a right to complain about privacy violations. Your consent must be obtained before the information in your records can be disclosed for treatment, payment, or any health care operations. We will contact you if there is a breach of your Protected Health Information.

If you want more information about our privacy practices, have questions or concerns, or if you are concerned that we may have violated your privacy rights, please contact: **General Manager for SAMRTEETH DENTAL at 951-256-4556.**

By signing the Acknowledgement of receipt form, you have given us permission to release your personal and health information for health care and dental consultations and referrals, billing, collections, and drug prescriptions. If you refuse to sign the Acknowledge of Receipt form, we will not be able to utilize your dental insurance as a means of payment.

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PRIVACY PRACTICES ACKNOWLEDGEMENT

You May Refuse to Sign This Acknowledgement

I, _____ have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Signature of Patient **Date**

(If patient is a minor, Parent or Guardian)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communications barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)