Smile Studio
Associates Dentistry
Dr. Raul Gonzalez
www.smilestudiodentistry.com

Patient Information

Patient Name:_____ D.O.B.___/___/____
Address: _____ Apt. #:
City: _____ State:_____ Zip: _____
Phone: H (____) _____ W (____) _____ C (__) _____
Email:_____ S.S#_____
Employer: _____ Work Address:_____
Occupation:_____
Referred by:_____
How did you know about us?

Responsible Party in Case of Emergency:
Name:_____ Address:_____
Phone: H (___) _____ W (___) _____ C(__)_____
Relationship to patient:_____

Insurance Information

Insurance Co.: _____
Phone: (___)_____ Group#: _____
Primary Insured:_____ Member S.S#:_____
Employer: _____ D.O.B.___/___/____

Release:

*I authorize the Dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
*I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.
*I authorize the release of any information concerning my health care, advice to another dentist.
*I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
*I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill of service. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid in whole or in part by my dental care payer.
*I attest to the accuracy of the information on this page.

Patients/Guardians Signature:_____ Date: _____

HEALTH HISTORY

English

Patient Name: _

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If **YES,** why?
4. Yes No Are you being treated by a physician now? What for? _____
   Date of last medical exam: Date of last Dental exam:
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DOYOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects[9]
31. Yes No Heart murmurs?
32. Yes NO Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma. TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to, please specify:_____
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS.
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No Svphilis or Gonorrhea
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51, Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?

Please list:_____

63. Yes No Tobacco in any form?
64. Yes No Alcohol?

VI. WOMEN ONLY:

65. Yes **No** Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_ _____

To the best of my knowledge, I have answered even' question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ **Date:** _____

Consent Form

I authorize Smile Studio to use all medicaments and therapeutic procedures necessary to complete my dental treatment as required (after treatments have been discussed and approved by patient).

I understand that dental treatment may consist of the usage of local anesthesia for the performance of Root Canal Treatments, Implant Surgery, Periodontal Surgery, Extractions, and Veneers.

I also certify that my treatment plan, along with benefits and risks have been completely explained to me and all of my questions have been adequately answered.

Payments must be made at the time the service is rendered. I understand estimates are approximate and may change if there are any unforeseen complications during treatment.

I also understand that Smile Studio is continuously involved in Continuing 'Education Courses. Therefore, my treatment can be used as a case, presentation during Smile Studio lectures (after your case has been discussed and approved by patient).

I also allow the use of my dental treatment for marketing purposes in the form of before and after smiles photographs, without the publication of any personal information, unless my prior approval of testimonials.

Smile Studio is committed to providing our patient with the highest quality of dental services. However, the success of all treatment also depends on the patient's compliance with post-operatory instructions and the-adherence to oral hygiene appointments every three or six months.

Patient's signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address:_____

Telephone (____) _____ Email: _____

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 options.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosure 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 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Name:

Telephone: _____Fax:

Email: _____

Address:

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 the 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 or to continue treating 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.

Signature:_____ Date:_____

FINANCIAL POLICY

In order to avoid any confusion about the payment policies of this office or the utilization of your dental insurance, we have assembled the following outline to help answer any questions that may arise. If you have any other questions please feel free to ask us any time.

PAYMENT POLICY: In an effort to make needed services more affordable, we have initiated a policy to encourage payment when services are rendered. This plan helps to reduce your cost and our overhead without diminishing the quality of our services.

*We DO accept all major Credit Cards,
Care Credit (please let us know in advance
for processing purposes).
*** Payment is due when services are rendered.**
***AFTER 60 DAYS OF NON PAYMENT
EITHER BY INSURANCE OR PATIENTS
YOU AGREE TO PAY INTEREST 1.50%
UNTIL FULL AMOUNT IS PAID.**
***AFTER 90 DAYS, YOU AGREE THAT
SMILE STUDIO MAY RENDER YOUR
ACCOUNT TO A THIRD PARTY
RECEIBABLE COMPANY AND YOU WILL
PAY ALL ACCRUED INTEREST FEES AND
LEGAL COLLECTION FEES AS DEEMED
PERMISABLE BY THE LAW.**

INSURANCE POLICY: We are happy to accept your dental insurance and with you and your insurance company.

*We will compute an estimate of your percentage of payments at each visit; this payment is due at the time services are rendered.
*If an insurance account shows an overdue balance, the patient should assume that the insurance company has paid its share and the present balance due is the responsibility of the patient. After the balance is paid. If you feel your insurance has made a mistakes, we will gladly provide the information necessary so your can be reimbursed by your insurance company.
*Any question concerning the reasoning behind insurance payments should be addressed to either your employer or insurance company.
*Please remember that any responsibility due rests with the patient.

Please let us know if we can be of any assistance, we will be glad to help you.

Name _____ Date _____

Signature _____

Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claims. If you have any questions please ask us. Thank you.

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within the 90 days, I will be responsible for the full amount owed to Smile Studio Associates Dentistry.

I understand and agree that I am responsible for the estimated amount not paid by the insurance company.

I understand that after the insurance company pays to Smile Studio & Assoc. there could still be a balance remaining, for which I am responsible.

I understand and agree that I am responsible for any portion of my balance not covered by insurance.

I understand and agree that if the estimate by the insurance company indicates a large amount due by me and I feel I cannot pay it during treatment, I can request a written financial agreement (terms to be discussed at that time).

I understand that any balance remaining after insurance and termination of treatment must be paid by me to Smile Studio Associates Dentistry. within the 90 days of the termination of treatment. If I fail to do so other methods of collection may be used including legal means to collect the debt if any, and all expenses incurred for this purpose will be added to my account. .

_____ _____

Signature of responsible party Office manager

_____

Date

INSURANCE POLICY

Our staff is trained to help you with any questions you may have relating to your insurance coverage and we will always do our best to help you maximize your benefits.

0-30	We will submit your insurance within 30 days from your date of service.
30-60	We expect payment from your insurance company within 30-60 days.
60-90	If your insurance company has not paid your claim within 90 days we would appreciate your cooperation by providing you with your insurance information so that you personally can follow up with your insurance claim.
	If any payments are made directly to you by your insurance company on unpaid balances should be forwarded immediately to our offices so that your account may be credited accordingly.

I have read, understood, and agree with the above statements. I understand that ultimately my account is my responsibility.

_____ _____

Patient signature Date