ENDLESS SMILES CO.

10783 NW 41st Street | Doral, FL 33178
305.539.9090 | endlesssmilesco.com

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have questions or need assistance, please ask us, we will be happy to help.

Date:_____
Patient #:_____

PATIENT INFORMATION (CONFIDENTIAL)

Name: _____ Birth Date: _____ S.S. #:_____
Home Phone: _____ Cell Phone: _____E-mail: _____
Address: _____City: _____State: _____ Zip:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer _____ Work Phone: _____
Business Address:_____City: _____State: _____ Zip:_____
Spouse or Parent's Name _____Employer _____Work Phone _____
If Patient is a Student, Name of School / College _____City _____ State _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone: _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Driver's License # _____ Birthdate _____Financial Institution_____
Employer _____ Work Phone _____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City: _____ State: _____Zip:_____
Insurance Company _____ Group # _____ Union or Local #_____
Ins Co. Address _____ City: _____ State: _____Zip:_____
How much is your Deductible? _____ How Much Have You Used?_____Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient _____
Birthdate _____Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City: _____ State: _____Zip:_____
Insurance Company _____ Group # _____ Union or Local #_____
Ins Co. Address _____ City: _____ State: _____Zip:_____
How much is your Deductible? _____ How Much Have You Used?_____Max. Annual Benefit _____

Patient Medical History

Physician _____ **Office Phone** _____ **Date of Last Exam** _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If Yes, what medication(s) are you taking?		
_____		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol?	☐	☐
6. Do you use cocaine or other drugs?	☐	☐
7. Do you wear contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (eg. novacaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

9. Women Only:	Yes	No
a) Are you pregnant or think you might be pregnant?.	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexualty Transmitted Disease	☐	☐	Other	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐			

Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐	8. Do you have frequent headaches?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	9. Do you clench or grind your teeth?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	10. Do you bite your lips or cheeks frequently?	☐	☐
4. Do you feel pain on any of your teeth?	☐	☐	11. Have you ever had any difficult extractions in the past?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐	12. Have you had any orthodontic work?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐	13. Have you ever had any prolonged bleeding following extractions?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?			14. Have you ever had instructions on the correct method of brushing your teeth?	☐	☐
a) Clicking?	☐	☐	15. Have you ever had instructions on the care of your gums?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐			
c) Difficulty in opening or closing?	☐	☐			
d) Difficulty in chewing?	☐	☐			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnostics and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize to takes pictures and videos for scientific and marketing purposes. ☐ Yes ☐ No

X _____

Signature of patient or parent if minor

Doctor's Comments _____

Signature _____ Date _____

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FINANCIAL POLICY

In an effort to keep fees reasonable, and to continue to provide quality care, we have established a payment policy. By executing this agreement, you are agreeing to pay for all services that are received.

Payments: Our administrative Team will work with you to handle your financial needs; however we do require all routine treatment paid in full at the time of the service. If a financial contract is signed, payment is expected on the agreed due date, outlined in the contract. If a payment billing arrangement is made, the balance of your account is due and payable when the statement is issued and is past due if not paid within 30 days.

Forms of Payments: Cash, Check and Credit Cards are all acceptable forms of payments. We accept MasterCard, Visa, American Express and Discover. In addition, we also offer third party financing, with processing taking only a few minutes. This is especially convenient if you will be having a comprehensive treatment plan.

Insurance: The financial coordinator will help you and your individual needs. If you have insurance benefits, we can provide an ESTIMATE of what your insurance company is expected to pay, but can make no guarantee of estimated coverage. All charges are your responsibility from the date services are rendered.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we must refer your debt to a collection agency, you agree to pay additional collection costs incurred from address searches, credit reports or attorney fees which can possibly equal 50% of the balance due. We may also take the claim to Small Claims Court. You agree to pay any court fees incurred in trying to collect the past due balance.

Returned Checks: There is a fee for any checks returned by the bank. The fees can range from $25-$40 depending of the amount of the check written. We prefer payment in cash on accounts with a history of a returned check.

Missed Appointment Fee: The second time a patient does not show up for an appointment, or cancels with less than 24 hours' notice, we have the right to charge a $50.00 fee. Extenuating circumstances will be considered. This fee must be paid before a new appointment may be made.

Divorce: In case of divorce or ·separation, the party responsible for the account prior to the divorce or separation, remains responsible for the account. After a divorce or separation, the parent authorizing treatment (signing consents) for a child will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is authorizing parent's responsibility to collect from the other parent.

I have read and understand the financial policy outlined above.

_____	_____
Patient's Name	Responsible Party
_____	_____ _____ / _____ / _____
Relationship to Patient	Signature Date

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I hereby consent to the use and disclosure of my health information for the purposes and the activities under the federal privacy law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling.

_____ _____ / _____ / _____

Patient's Name (Please Print) Date

_____

Signature (If minor, Parent or Guardian)

_____

Patient's Legal Representative (If applicable)

_____ _____ / _____ / _____

Signature of Legal Representative Date

FOR DENTAL 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
___ Communication barriers prohibited obtaining the ACKNOWLEDGEMENT
___ An emergency situation prevented us from obtaining ACKNOWLEDGEMENT
___ Other, (Please Specify) _____

_____

NOTICE OF PRIVACY PRACTICES

ENDLESS SMILES CO.

Protecting Your Confidential Health Information Is Important To Us

Notice of Privacy Practices

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

Our Promise !

Dear Patient:

This is not meant to alarm you! Quite the opposite!
It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So, what has changed?
Why a privacy policy now?
Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. Our policies and procedures will be put in writing to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures, developed to make sure your health information will not be shared with anyone who does not require it. We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

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 treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certifications, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, 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.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include 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 will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or 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

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information, and only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Print Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing your again soon!

_____

Patient signature

Date _____

Patients Rights

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

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make ever y effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete.We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process,please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Please let us know in writing the time period for which you are interested. We may need to charge you a reasonable fee for your request.

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, or email a copy to you.

You have the right to express complaints to us or to the Secretary of Health 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

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PATIENT'S COMUNICATION METHOD

PATIENT'S NAME: _____

HOME PHONE NUMBER:___(_____)_____

CELL PHONE NUMBER: ___(_____)_____

WORK PHONE NUMBER:___(_____)_____

EMAIL ADDRESS:_____

To serve you better, we would like for you to select your appointment confirmation preference. Please check the appropriate form of confirmation desired.

- ☐ HOME PHONE NUMBER
- ☐ CELL PHONE NUMBER
- ☐ WORK PHONE NUMBER
- ☐ TEXT MESSAGE
- ☐ EMAIL ADDRESS
- ☐ NONE OF THE ABOVE