UPPER EAST SMILES

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to assist you.

Patient Information

Last Name: _____ First Name: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip Code: _____ Email: _____
Home #: _____ Cell #: _____ Business #: _____
Sex: Male / Female Age: _____ DOB: _____ Are you: Single Married Child Other
Employer: _____ Occupation: _____
Business Address: _____ Business #: _____
Emergency Contact: _____ Relation: _____
Home #: _____ Cell #: _____ Business #: _____
Referred by: _____

Dental History

What is your primary concern? _____
Are you in pain or discomfort? _____ If Yes, please explain: _____
Last dental visit: ___/____/____ Last dental x-rays taken: ___/____/____ How often do you brush? _____
How often do you floss? _____ How do you feel about your smile? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y/N

Medical History

Physician's Name: _____ Phone #: _____
Date of last medical exam: _____/_____/_____ Is your general health good? Y/N
Has there been a change within the last year? Y/N Have you been hospitalized or had a serious illness? Y/N
If yes, please explain: _____
Are you being treated by a physician now? Y/N For what conditions? _____
Have you ever used bisphosphonates? Y/N Are you taking aspirin? Y/N Are you taking any blood thinners? Y/N
For Women: Are you or could be pregnant or nursing? Y/N Taking birth control pills? Y/N

Medical History: Do you or have you had (Please circle either Yes / No): If none to all, please cross out the section.

Yes / No Chest pain (angina)	Yes / No Difficulty swallowing	Yes / No Shortness of breath
Yes / No Dizziness	Yes / No Recent weight loss, fever	Yes / No Fainting or Seizures
Yes / No Persistent cough	Yes / No Blurred vision	Yes / No Sinus problems
Yes / No Dry mouth	Yes / No Prosthetic heart valve	Yes / No Artificial joint
Yes / No Heart conditions	Yes / No Heart murmur	Yes / No Heart attack
Yes / No Rheumatic fever	Yes / No HIV/AIDS	Yes / No Tumors or Cancers
Yes / No Stroke	Yes / No Arthritis, rheumatism	Yes / No Anemia or bleeding problems
Yes / No High blood pressure	Yes / No Asthma, TB, emphysema	Yes / No Other lung disease
Yes / No Kidney, bladder disease	Yes / No Hepatitis, other liver disease	Yes / No Thyroid or adrenal disease
Yes / No Stomach ulcers	Yes / No Diabetes	Yes / No STD
Yes / No Psychiatric care	Yes / No Radiation therapy	Yes / No Chemotherapy
Yes / No Pacemaker	Yes / No Anaphylaxis	Yes / No Cortisone treatments

Are you taking (Please select Yes / No):

Yes/ No Tobacco in any forms Yes/ No Recreational drugs Yes/ No Alcohol

Do you have any known allergies to drugs, food, medications, latex? _____
Are you currently taking any medications? If yes, please list all:

_____

Do you have or have you had any other medical conditions NOT listed on this form? _____

_____

UPPER EAST SMILES

GENERAL CONSENT FOR ROUTINE TREATMENT

I am seeking health care and treatment for _____ (Patient Name) from Upper East Smiles, PC and voluntarily consent to receive dental services, which may include routine diagnostic and therapeutic dental procedures and routine dental treatment to be provided by duly licensed independent practitioners and other personnel. I acknowledge that no guarantees have been made to me as to the results of treatments or examinations by Upper East Smiles, PC. I understand that this consent is valid and shall remain in effect unless I revoke it. I understand that this general consent applies to any routine procedure or treatment, such as administration of medication, injections, external examination of the body, including the mouth, use of local anesthesia, and other routine procedures.

I consent to the photographing and/or videotaping of the appropriate portions of my/the patient's body, which are pertinent to showing my/the patient's physical condition, for medical, scientific or educational purposes, provided reasonable precautions are taken to conceal my/the patient's identity.

I understand that I may ask questions of my/the patient's licensed independent practitioners and other personnel regarding any aspect of my/the patient's diagnosis or treatments which I do not understand.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I assign and set over to Upper East Smiles, PC sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my dental or medical care to cover the costs of the care and treatment rendered to myself or my dependent. I understand that I am responsible for charges not covered by my insurance plan.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Upper East Smiles, PC to release to government agencies, insurance carriers, or others who are financially liable for dental and medical care, all information needed to substantiate payment for such care, and allow others who are representatives thereof to examine and make copies of all records relating to my care and treatment.

CONSENT TO ACCESS AND RELEASE INFORMATION TO ELECTRONIC PRESCRIBING MEDICATION HISTORY DATABASE

I authorize Upper East Smiles, PC to access all electronic prescribing medication history databases and to release my prescription medication history contained in and sent to an electronic prescribing medication history database used by Upper East Smiles, PC. I understand that the purpose of this form is for Upper East Smiles, PC to be able to access and exchange medication history information with authorized electronic prescribing services from other providers, pharmacies and/or third-party pharmacy benefit programs/payors.

By signing this form, I hereby state that I have answered every question completely and accurately to the best of my knowledge and that I have read, understood, and agreed upon the Assignment, Authorization and Consent written in this form. I will also inform my dentist of any change in my health and/or medication.

_____	_____	___/____/_____
Signature of Patient	Print Last Name, First Name	Date

If the patient is not authorized to give valid consent on his or her own behalf, the signature of one of the following persons must be obtained: Parent, Legal Guardian, Custodian, Spouse or Health Care Agent.

_____	_____	___/____/_____
Signature of Patient Representative	Print Last Name, First Name	Date

Indicate relationship to the patient and provide a copy of any required documentation:

__Parent __Legal Guardian (*A copy of the order appointing the guardian must be included in the patient's record*.)

__Spouse __Health Care Agent (*A copy of the Health Care Proxy form must be included in the patient's record*.)

__Custodian (*A copy of all available documentation authorizing custody must be included in the patient's record*.)

UPPER EAST SMILES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to Upper East Smiles, P.C. (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

CONSENT FOR COMMUNICATION

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

_____	(_____)_____	(_____)_____
Email Address	Cell #	Home #

_____	_____	_____/_____/_____
Patient's Signature	Patient's Last Name, First Name	Date

UPPER EAST SMILES

Dental Insurance Information

Insurance Name: _____ Insurance Phone #: _____

Insurance Address: _____

_____

City State Zip

Subscriber's Name: _____ SSN: _____ DOB ____/____/_____

Subscriber ID # _____

Family members covered under this plan: _____

School attended **Full Time** by dependents over age of 19 yrs. old: _____

Assignment of Benefits
I authorize payment of benefits to Upper East Smiles, PC and its doctors for dental services provided.

_____
Signature Date

Release of Information
I authorize the release of any dental information necessary to process claims.

_____
Signature Date

Cancellation and No-Show Policy

We take great pride in the quality of care that we deliver. In effort to maintain this high-level of care, we have instituted the following Cancellation and No-Show Policy. Please review it and complete where indicated.

I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide a 24-hour cancellation notice of any scheduled appointment at Upper East Smiles, PC.

The fee will be **$75.00** for any office visits. I understand this fee is not reimbursable by my insurance carrier and that I will be charged with this fee and that it will be reflected in my account.

By signing below, you are indicating that you have read and understood this policy.

_____ _____ _____/_____/_____
Signature of Patient Print Last Name, First Name Date