UPPER EAST SMILES

Patient Information
Last Name: _____
First Name: _____
Sex: ☐ Male ☐ Female DOB: _____/_____/_____
Are you: ☐ Single ☐ Married ☐ Other: _____
SSN: _____-_____-_____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____
Home #: _____ Cell #: _____
Employer: _____
Occupation: _____

Emergency Contact: _____
Relation: _____
Home #: _____Cell #: _____

Dental Insurance Information
Insurance Company: _____
Employer: _____
Subscriber's full name: _____
Date of birth: _____/_____/_____
Social Security Number: _____-_____-_____
Insurance Identification Number: _____
Plan/ Group Number: _____

Referred by: ☐ Internet Search ☐ Patient: _____ ☐ Other: _____

Medical History
Physician's Name: _____
Phone #: _____
Date of last medical exam: _____/_____/_____
Is your general health good? ☐ YES ☐ NO
Has there been a change within the last year? ☐ YES ☐ NO
Were you ever hospitalized? ☐ YES ☐ NO
Have you had a serious illness? ☐ YES ☐ NO
Are you being treated by a physician now? ☐ YES ☐ NO
For what conditions? _____
Have you ever used bisphosphonates? ☐ YES ☐ NO
Are you taking aspirin? ☐ YES ☐ NO
Are you taking any blood thinners? ☐ YES ☐ NO

For Women:
Are you or could be pregnant or nursing? ☐ YES ☐ NO

Dental History
What is your primary dental concern? _____
_____
Are you in pain or discomfort? ☐ YES ☐ NO
If Yes, please explain: _____
Last dental visit: _____/_____/_____
Last dental x-rays taken: _____/_____/_____
How often do you brush? _____/ day
How often do you floss? _____/ day
How do you feel about your smile? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?
Please select one: ☐ YES ☐ NO

Taking birth control pills? ☐ YES ☐ NO

Medical History: Do you or have you had (Please check either YES or NO)

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia or bleeding problems	☐	☐	Dizziness/ Fainting	☐	☐	Lung disease
☐	☐	Anaphylaxis	☐	☐	Dry mouth	☐	☐	Pacemaker
☐	☐	Arthritis, rheumatism	☐	☐	Epilepsy or Seizures	☐	☐	Persistent cough
☐	☐	Artificial joint	☐	☐	Heart attack	☐	☐	Prosthetic heart valve
☐	☐	Asthma, TB, emphysema	☐	☐	Heart disease	☐	☐	Psychiatric care
☐	☐	Cancers / Tumors	☐	☐	Heart murmur	☐	☐	Rheumatic fever
☐	☐	Chemotherapy/ Radiation	☐	☐	Hepatitis, other liver disease	☐	☐	Sinus problems
☐	☐	Chest pain (angina)	☐	☐	HIV/AIDS	☐	☐	Stomach ulcers
☐	☐	Cortisone treatments	☐	☐	High blood pressure	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Kidney, bladder disease	☐	☐	Thyroid or adrenal disease
☐	☐	Difficulty swallowing	☐	☐	Other: _____			

Are you using/ taking (Please check either YES / NO**):**
Tobacco in any forms ☐ YES ☐ NO Recreational drugs ☐ YES ☐ NO Alcohol ☐ YES ☐ NO
Do you have any known *allergies* to **drugs, food, medications, latex**? ☐ YES ☐ NO

_____
Are you currently taking any medications? ☐ YES ☐ NO
If yes, please list all: _____
Do you have or have you had any other medical conditions **NOT** listed on this form? _____
_____

GENERAL CONSENT FOR ROUTINE TREATMENT: I am seeking health care and treatment for _____ (Patient Name) from Upper East Smiles, PC (the "Practice") 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 (L.I.P.) and other personnel. I acknowledge that no guarantees have been made to me as to the results of treatments or examinations by the Practice. 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 L.I.P. and other personnel regarding any aspect of my/the patient's diagnosis or treatments which I do not understand.

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/ text messaging 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.

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.

Cancellation/ Reschedule 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/ Reschedule 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/ reschedule 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 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. 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.

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