Wyoming Smile Center
Care You Can Count On

New Patient Forms

Patient Information

Name: _____ Today's Date: _____

Preferred Name: _____ Birth Date: _____ SSN:_____

Email Address: _____

Mailing Address: _____

Phone: _____ ☐cell phone ☐landline

How did you hear about us: _____

Emergency Contact Name and Phone Number: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are required by law to:
- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice currently in effect

Protected health information includes information that identifies you and relates to your dental or health condition, treatment, or payment for services.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment
   a. We may use or disclose your health information to provide, coordinate, or manage your dental care. Example: Sharing information with specialists, labs, or other healthcare providers involved in your care.
2. Payment
   a. We may use or disclose your health information to obtain payment for services provided. Example: Submitting claims to your dental or medical insurance plan.
3. Health Care Operations
   a. We may use or disclose your health information for practice operations, including quality assessment, staff training, licensing, and administrative activities.

SUBSTANCE USE DISORDER (SUD) RECORDS - SPECIAL PRIVACY PROTECTIONS

Some health information related to substance use disorder (SUD) diagnosis, treatment, or referral may be protected by federal law (42 CFR Part 2) and receives additional confidentiality protections.

Important information about SUD records:
• We may not use or disclose SUD records for treatment, payment, or healthcare operations without your written consent, except as permitted by law.
• These records will not be used or disclosed in any civil, criminal, administrative, or legislative proceeding against you without your written consent or a court order.
• If state or federal laws are more restrictive than HIPAA, those stricter laws will apply.

REDISCLOSURE NOTICE

If your health information is disclosed as permitted by law, the recipient may redisclose the information, and it may no longer be protected by HIPAA.

FUNDRAISING COMMUNICATIONS (If Applicable)

We will not use information protected under 42 CFR Part 2 for fundraising without giving you the opportunity to opt out of such communications.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- Inspect and obtain a copy of your health records
- Request corrections to your health information
- Request restrictions on certain uses or disclosures
- quest confidential communications
- ceive a paper copy of this Notice at any time
- notified if your unsecured health information is breached

OTHER USES AND DISCLOSURES

Any uses or disclosures of your health information not described in this Notice will be made only with your written authorization. You may revoke an authorization at any time in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to all health information we maintain. The revised notice will be available in our office and on our website.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with:
Practice Manager: Brandi Bishop, 513-761-1900
Or with the U.S. Department of Health and Human Services:
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-800-368-1019 | www.hhs.gov/ocr
We will not retaliate against you for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of this Notice of Privacy Practices.

Patient Name (Printed): _____

Signature: _____ Date: _____

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

1. I hereby authorize all health care providers to use and/or disclose the protected health information ("PHI") described below to me or directed below. The purpose of this request is for personal reasons.

2. I hereby authorize the release of PHI, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information. I understand that my personal billing, financial and insurance information may be disclosed to those in section 3 in order to be able to process claims with the insurance company and/or for personal reasons.

3. In addition to the authorization for release of my PHI, I authorize disclosure of information regarding my/my spouse or domestic partner/my dependent's billing, condition, treatment and prognosis to the following individual(s) (please caregivers that may accompany children to appointments):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

4. This medical information may be used by the persons I authorize to receive this information for dental/medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and in effect until I am no longer a patient at this practice.

6. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation.
.

Print Name: _____ Date: _____

Patient Signature (or Parent/Guardian): _____

Appointment Confirmation & Cancellation Policy Acknowledgement

Patient Name: _____ **Date:** _____

To help us provide timely care for all patients, we ask that you review and acknowledge the following appointment policies:

Appointment Confirmation Policy

Our office requires appointment confirmation no later than **12:00 PM (noon) on the business day prior to your scheduled appointment**.

If we do not receive confirmation by this deadline, your appointment may be cancelled and offered to another patient in need of care.

Cancellation Policy

We respectfully request a minimum of **24 hours' notice** if you need to cancel or reschedule your appointment.

Failure to provide at least 24 hours' notice may result in a **Missed Appointment Fee of $65.00**. This fee is assessed to help offset the time reserved specifically for your care.

Patient Acknowledgement

By signing below, I acknowledge that I have read, understand, and agree to the appointment confirmation and cancellation policies outlined above. I understand that failure to comply with these policies may result in cancellation of my appointment and/or assessment of a missed appointment fee.

Patient (or Parent/Guardian) Signature: _____

Date: _____

Financial Policy

Dental treatment is an excellent investment in you and your family's health and wellbeing. We recognize that the long range economy is of prime concern as well. The following rights and responsibilities are outlined below to aid in understanding our future dental relationship.

INSURANCE VERIFICATION AND ASSIGNMENT

● I certify that the information I have provided about my active dental insurance coverage is correct to the best of my knowledge

● I authorize the release of any dental/medical records or other information including diagnosis and treatment rendered to me, as requested by my dental insurance carrier

● I authorize the assignment of benefit payment(s) from my insurance carrier(s) directly to the assigned dental office and the practitioner who provided service(s) to me.

Patient's initials _____

FINANCIAL RESPONSIBILITY

I understand that PAYMENT IN FULL is expected at the time of my appointment. I understand that if I come on the day of my appointment without one of the acceptable forms of payment listed below, the office has the right to reschedule my appointment. We also believe financial considerations should not be an obstacle to obtaining treatment. In situations involving large treatment plans, we provide the following payment options:

CASH, MONEY ORDER, CERTIFIED CHECKS, ALL MAJOR CREDIT CARDS. Returned checks will be charged a $35 NSF fee on the patient account.

AFFORDABLE MONTHLY PAYMENT PLANS (SUBJECT TO APPROVAL). These are outside financing arrangements specifically designed for dentistry and related specialties - with AFFORDABLE MONTHLY payments via Care Credit.

In the event the charges incurred are not paid in full when due and collection action is instituted, I understand I am responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs/or any other expenses incured in its collection as allowable by law.

CANCELLED AND MISSED APPOINTMENTS I understand that if I find it impossible to keep a scheduled appointment, I must let the office know at least 48 hours in advance so that another patient may use the time reserved for me. We reserve the right to charge $65 for any missed appointment when not given 24 hour notice of cancellation/reschedule.

PATIENTS WHO HAVE DENTAL INSURANCE BENEFITS

Payment is expected on the day of treatment unless other arrangements have been made prior to the appointment. As a COURTESY, we will submit the fees for your treatment to your insurance company on your behalf. **However, the financial responsibility and legal obligation for any uncovered treatment remains with you, including any remaining balance, even though an estimated co-payment may be collected at the time of your appointment.** We will attempt to gain as many benefits as possible from your insurance company; we are

not a party to that contract. We accept the assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 60 days will be billed to you, the patient.

If needed, a pre-treatment estimate will be sent to your insurance company to determine what benefit you may receive. Patients are responsible for any “patient portion” not covered by insurance, which will be due at the time of service. Please be advised, this is an ESTIMATE and not a promise or guarantee of coverage from the insurance carrier.

Patient Signature: _____ Date:_____

Medical History (Circle Y for YES or N for NO)

Y N Are you under medical treatment now?
Y N Do you use alcohol?
Y N Do you use tobacco? If yes circle which apply:
Cigarettes Cigars Chewing Tobacco Vape
Y N Have you ever received treatment for controlled substance abuse?
Y N Have you ever taken prescription medication for weight loss (diet Pills)? If yes, did you take any of the following*(circle which apply):*
Fen-Phen Pondimen Redux Other
Y N Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other similar drugs?
Y N Have you been hospitalized for any surgical operation or serious illness within the last 5 years?
If so: When _____ What for _____
Y N Have you had a study for sleep apnea done?
Y N What kind of water do you generally consume? *Circle One:* well city bottled
Y N If well or bottled have you had your water tested for fluoride?
Y N Are you currently taking any medication, drugs, pills, herbal remedies, non-prescription medication or regular dosages of aspirin? If yes, please give name(s) and dosage:

_____
_____
_____
_____
_____

How many sugared or no calorie sweetened beverages (soda, energy drinks, juice. flavored water, etc.) do you consume per week? Circle: 0-10 10-25 over 25

Do you have any of the following:

Y N Low Blood Pressure
Y N High Blood Pressure
Y N Diabetes
Y N Kidney Disease
Y N Heart Attack Y N AIDS or HIV (positive)
Y N Thyroid Problems
Y N Heart Disease
Y N Frequently Tired
Y N Cardiac Pacemaker
Y N Anemia
Y N Arthritis
Y N Angina
Y N Eating Disorder
Y N Chest Pains
Y N Joint Replacement
If so, Which Joint: _____ When: _____

Y N Easily Winded
Y N Stroke
Y N Hepatitis- *Circle Please:* A B C
Y N Rheumatic Fever
Y N Stomach Troubles/Ulcers
Y N Mitral Valve Prolapse
Y N Seasonal Allergies
Y N Heart Murmur
Y N Glaucoma
Y N Swollen Ankles
Y N Liver Disease
Y N Fainting/Seizures
Y N Tuberculosis
Y N Epilepsy/Convulsions
Y N Respiratory Problems
Y N Leukemia- When: _____
Y N Emphysema
Y N Asthma
Y N Cancer- When: _____
Y N COPD
Y N Sickle Cell Disease
Y N Chemotherapy- When: _____
Y N Hemophilia
Y N Radiation Therapy- When: _____
Y N Other

Do you have or have you had any disease, condition, or problem not listed? *If yes, please list:*
_____
_____
_____
_____

Are you allergic to or have you had any reactions to the following?
Y N Local Anesthetics (e.g. novocaine)
Y N Penicillin
Y N Sulfa Drugs
Y N Barbiturates
Y N Sedatives
Y N Iodine
Y N Codeine
Y N Aspirin
Y N Any metals (e.g. nickel, etc.)
Y N Latex rubber
Y N Wheat
Y N Red Dye

Other : _____

Women only:
Y N Are you or think you may be pregnant?
Y N Are you nursing?
Y N Are you taking oral contraceptives?

Dental History (Circle Y for YES or N for NO)

Y N Do your gums bleed while brushing or flossing?
Y N Have you ever been treated for gum disease or been told you have bone loss?
Y N Do you frequently have dry mouth or have difficulty swallowing?
Y N Are your teeth sensitive to hot or cold liquids or foods?
Y N Have you had cavities in the past 3 years?
Y N Do you feel pain in any of your teeth?
Y N Do you have any sores or lumps in or near your mouth?
Y N Have you had prolonged bleeding after extractions?
Y N Do you bite your lips or cheeks frequently?
Y N Have you had orthodontic treatment before?
Y N Do you wear dentures or partials?
Y N Have you received oral hygiene instructions regarding the care of your teeth and gums?
Y N Have you had frequent ear problems?
Y N Do you have sleep apnea? If YES circle: diagnosed undiagnosed
Y N Do you wear a CPAP at night?
Y N Do you like your smile?
Y N Have you ever had your teeth ground or the bite adjusted?
Y N Do you clench or grind your teeth at night or wake up with sore teeth or jaw?
Y N Have you ever had a bite plate or mouth guard?
Y N Are you happy with how your teeth look?
Y N Are you happy with how your teeth function?
Y N Do you feel nervous about dental treatment?

Have you ever had any complications following dental treatment? If yes, please explain:

_____
_____
_____

Do you have any dental concerns currently? If yes, please explain:

_____
_____
_____

What is the reason for your visit today?

_____
_____
_____

How often do you brush your teeth?

_____
_____
_____

How often do you floss?

_____
_____
_____