SmileWell Dental
ORAL HEALTH & SMILE DESIGN

Patient Information

Patient Name: _____ Date: _____
Male_____ Female_____ Married_____ Single_____ Child_____ Other_____
Address_____
Street City State Zip
Social Security #_____ Birth Date_____ e-mail_____
Home Phone_____ Work Phone_____ Cell Phone_____

Responsible Party Information

Patient Name: _____ Date: _____
Male_____ Female_____ Married_____ Single_____ Child_____ Other_____
Address_____
Street City State Zip
Social Security #_____ Birth Date_____ e-mail_____
Home Phone_____ Work Phone_____ Cell Phone_____

Employment Information

The following is for ____ The Patient _____ The Person Responsible for payment
Employer Name_____ Occupation_____
Address_____
Street City State Zip

Referral Information

Whom may we thank for referring you to our practice?
Another patient, friend, relative_____ Referring Dr._____ Insurance Plan_____ Internet_____
Name of Person or Office referring you to our practice_____

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Insurance Information

Primary

Name of Insured _____ SS#_____
Insured's Birth Date_____ ID#_____ Group # _____
Insured's Employer Name_____
Patient's relationship to Insured ____Self ____ Spouse ____ Child ____ Other _____
Insurance Plan Name _____ Phone _____
Address _____
Street City State Zip

Secondary

Name of Insured _____ SS#_____
Insured's Birth Date_____ ID#_____ Group # _____
Insured's Employer Name_____
Patient's relationship to Insured ____Self ____ Spouse ____ Child ____ Other _____
Insurance Plan Name _____ Phone _____
Address _____
Street City State Zip

Health Information

Date of Last Dental Visit _____ Reason for this Visit _____

- Have you ever had any complications following dental treatment? _____No _____ Yes
  If yes, please explain_____
- Have you been admitted to a hospital or needed emergency care during the past two years?
  ____ No ____ Yes If yes, please explain_____
- Have you recently undergone surgery? _____No_____Yes
  If yes, please explain_____
- Are you under the care of a physician? _____No_____ Yes
  If yes, please explain _____
- Do you have any health problems that need further clarification? _____No _____ Yes
  If yes, please explain _____

Name of Physician_____ Phone _____

Please list all Medication_____
Have you ever had an ALLERGIC reaction? ____N _____Yes
If yes, please list allergies:_____

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Do you take Pre-Medications for Dental Procedures? _____NO _____Yes
If yes, please explain_____

Have you ever had or have any of the following? Please check all that apply:

__HIV/AIDS
__Anemia
__Arthritis
__Artificial Joints
__ Asthma
__ Blood Disease
__ Cancer
__ Diabetes
__ Dizziness
__ Epilepsy
__ Excessive Bleeding
__ Fainting
__ Glaucoma
__ Growths
__ Hay Fever
__ Head Injuries
__ Heart Disease
__ Heart Murmur
__ Hepatitis
__ High Blood Pressure
__ Jaundice
__ Liver Disease
__ Mental Disorders
__ Nervous Disorders
__ Pacemaker
__Pregnant
due Date_____
__ Radiation Treatment
__ Respiratory Problems
__ Rheumatic Fever
__ Rheumatism
__ Sinus Problems
__ Stomach Problem
__ Kidney Disease
__ Stroke
__ Tuberculosis
__ Tumors
__ Ulcers
__ Venereal Disease
__ Codeine Allergy
__ Latex Allergy
__ Penicillin Allergy
__ Eating disorders

PLEASE SELECT ONE SECTION ON EACH LINE:

___ My mouth is comfortable ___My mouth is moderately comfortable ___My mouth is uncomfortable

___My smile is excellent ___I would like to change my smile ___I am unconcerned about my smile

___ I will do whatever I must to keep my teeth __I want to keep my teeth, but only within a certain budget of time and money

___I've done the dentistry recommended to me ___I've not done dentistry recommended to me
My Dental Heath is ___Excellent ___ Good ___Fair ___Poor

Concerns I would like addressed today_____

_____

_____

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Consent for Services

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are preformed.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- A service charge will be applied to any unpaid balance on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- In the event the balance becomes more than 90 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.
- I understand that the fee estimate listed for the dental care can only be extended for a period of six months from the date of the patient examination.
- In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to the said Doctor, or his assignee, at the time said services are rendered, or with five days of billing if credit shall by extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.
- I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
- I hereby grant permission to confer with the following regarding my treatment and account.
- _____

  Name of person(s)

I have read the above conditions of treatment and payment and agree to their content

_____Date _____ Relationship to Patient _____
Signature of Patient, parent or guardian

_____ Date _____ Relationship to Patient _____
Signature of guarantor of payment/responsible party

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NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how Healthcare information about you may be used by Dr. Jeanine Sasek. A full notice of your privacy rights has been provided to you.

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public health, research, health and safety, government, works compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Complaints. You may complain to the Privacy Information Director at 206.223.0033 or to the Department of Health and Human resources if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

"I acknowledge that I have received the full Privacy Notice."

_____Date _____ Relationship to Patient _____
Signature of Patient, parent or guardian
_____ Date _____ Relationship to Patient _____
Signature of guarantor of payment/responsible party