Part 1: PATIENT INFORMATION

Name____________________________Address______________________________E-Mail ___________________________________

City__________________________________State___________ Zip____________Birth Date________________ Sex ____________

Home Phone__________________________ Cell #________________________Employer_____________________________________

Soc. Sec. #_____________________ Emergency Contact ___________________Phone #_______________Relation _____________

Part 2: FINANCIAL AND INSURANCE INFORMATION

If you would like to use your dental insurance, please fill out the following:

Insured's Name________________________ **Insured's Soc. Sec. #** _________________**Insured's date of birth** ______________

Insurance Co. ____________________Insured's relationship to patient _____________ Insured's Employer _________________

Secondary coverage Information

Insured's Name________________________ **Insured's Soc. Sec. #** _________________**Insured's date of birth** ______________

Insurance Co. ____________________Insured's relationship to patient _____________ Insured's Employer _________________

We accept cash, Visa, MasterCard, Discover, debit cards, and dental insurance. We also have payment plans available through Care Credit. If you would like to apply, please let us know. I authorize payment directly to Cleveland Smile Center, and any portion of my bill not covered by insurance is my responsibility. Payment is expected at the time services are rendered.

When cancelling an appointment, patients are required to notify the office at least 48 hours in advance. Our policy is to charge $85 for missed appointments. We reserve the right to permanently dismiss a patient from the practice if 3 consecutive appointments are missed. With my signature, I acknowledge the information provided will be utilized to submit treatment for insurance benefits.

SIGNATURE ____**DATE** ____________________________

Part 3: HELP US GET TO KNOW YOU

How can we help you smile? ____

Were you satisfied with your past dental treatment? ______ If not, why? ____

How would you describe a good dentist? ____

____

Are you pleased with the appearance of your teeth? Yes / No If no, what would you change? _________________________________

Would you like whiter teeth? Yes / No Do your gums ever bleed? Yes / No

Please rate Your Smile and Overall Dental Health (1-10*): _____

How would you describe your present dental health? ____

____

____

____

____

Part 4: HOW DID YOU HEAR ABOUT OUR OFFICE?

Flyer Google Facebook Insurance Our Sign Friend/Family Other_____________

Is there someone we can thank for referring you? ____

Part 5: MEDICAL HISTORY

Name____ Date______________________

Are you under a physician's care right now? ○Yes○Please explain, if yes ____

____

Have you ever been hospitalized or had a major operation? ○Yes○No If yes, please explain ____

Have you ever had a serious head or neck injury? ○Yes○No If yes, please explain ____

Are you taking any medications, pills or drugs? ○Yes○No If yes, please explain ____

Do you take, or have you taken, Phen-Fen or Redux? ○Yes○No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes○No
If yes, please explain____

Are you on a special diet? ○Yes○No

Do you use tobacco? ○Yes○No

Do you use controlled substances? ○Yes○No

Women Only: Pregnant/Trying to get pregnant? ○Yes○No Taking oral contraceptives? ○Yes○No Nursing? ○Yes○No

Are you allergic to any of the following?

○Aspirin ○Penicillin ○Codeine ○Sulfa drugs ○Local Anesthetics ○Epinephrine ○Latex ○Metal ○Other
If yes, please explain ____

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

AIDS/HIV Positive	○Yes○No	Cortisone Medicine	○Yes○No	Hemophilia	○Yes○No	Radiation Treatments	○Yes○No
Alzheimer's Disease	○Yes○No	Diabetes	○Yes○No	Hepatitis A	○Yes○No	Recent Weight Loss	○Yes○No
Anaphylaxis	○Yes○No	Drug Addiction	○Yes○No	Hepatitis B or C	○Yes○No	Renal Dialysis	○Yes○No
Anemia	○Yes○No	Eating Disorder	○Yes○No	Herpes	○Yes○No	Rheumatic Fever	○Yes○No
Angina	○Yes○No	Emphysema	○Yes○No	High Blood Pressure	○Yes○No	Rheumatism	○Yes○No
Arthritis/Gout	○Yes○No	Epilepsy or Seizures	○Yes○No	High Cholesterol	○Yes○No	Scarlet Fever	○Yes○No
Artificial Heart Valve	○Yes○No	Excessive Bleeding	○Yes○No	Hives/Rash	○Yes○No	Shingles	○Yes○No
Artificial Joint	○Yes○No	Excessive Thirst	○Yes○No	Hypoglycemia	○Yes○No	Sickle Cell Disease	○Yes○No
Asthma	○Yes○No	Fainting Spells/Dizziness	○Yes○No	Irregular Heartbeat	○Yes○No	Sinus Trouble	○Yes○No
Blood Disease	○Yes○No	Frequent Cough	○Yes○No	Kidney Problems	○Yes○No	Spina Bifida	○Yes○No
Blood Transfusion	○Yes○No	Frequent Diarrhea	○Yes○No	Leukemia	○Yes○No	Stomach/Intestinal Disease	○Yes○No
Breathing Problem	○Yes○No	Frequent Headaches	○Yes○No	Liver Disease	○Yes○No	Stroke	○Yes○No
Bruise Easily	○Yes○No	Genital Herpes	○Yes○No	Low Blood Pressure	○Yes○No	Swelling of Limbs	○Yes○No
Cancer	○Yes○No	Glaucoma	○Yes○No	Lung Disease	○Yes○No	Thyroid Disease	○Yes○No
Chemotherapy	○Yes○No	Hay Fever	○Yes○No	Mitral Valve Prolapse	○Yes○No	Tonsillitis	○Yes○No
Chest Pains	○Yes○No	Heart Attack/Failure	○Yes○No	Osteoporosis	○Yes○No	Tuberculosis (TB)	○Yes○No
Cold Sores/Fever Blisters	○Yes○No	Heart Murmur	○Yes○No	Pain in Jaw Joints	○Yes○No	Tumors or Growths	○Yes○No
Congenital Heart Disorder	○Yes○No	Heart Pacemaker	○Yes○No	Parathyroid Disease	○Yes○No	Ulcers	○Yes○No
Convulsions	○Yes○No	Heart Trouble/Disease	○Yes○No	Psychiatric Care	○Yes○No	Venereal Disease	○Yes○No

Have you ever had any serious illness not listed above? If yes, please explain ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE of Patient (Parent or Guardian)____ DATE________________________________

Comments:

____
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NOTICE OF PRIVACY PRACTICES

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

We support your right to the privacy of your health information. We are required by applicable federal and state law to maintain the privacy of your health information, and to provide you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our notice at any time.

USES AND DISCLOSURE IN HEALTH INFORMATION

This notice allows us to use and disclose health information about you or your minor child if you are a parent or guardian, as necessary for treatment, payment and healthcare operations. We will limit the release of information necessary to assist in the specific need. Examples include:

- **Treatment:** Schedules will be posted in our operatories to assist in providing treatment. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** Professional discretion is our goal. We may use and disclose your health information in connection with our healthcare operations, but will limit disclosure the specific information needed. This use includes coordination of treatment, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioners and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Persons Involved in Care: In the event of your incapacity, or in emergency circumstances, we will disclose health information directly relevant to healthcare or identification using our professional judgment. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization (below).

Abuse or Neglect: We are required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or the safety and health of others.

Contact Modes: We will use text, voice mail messages, answering machines, postcards, e-mails or letters if we cannot reach you personally. If we cannot speak with you directly, we will limit the information divulged as much as possible, except in matters of medical necessity.

PHOTOGRAPHY CONSENT RELEASE

I understand that the dentist as well as the clinical staff may need to take photographs in order to properly document and monitor the progress of my treatment. I understand and authorize to have photographs taken specifically relating to my dental treatment. I also authorize Cleveland Smile Center to display these pictures for use of internal and external marketing. All patient names and information will be kept confidential.

PATIENTS RIGHTS

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. If you request copies, we will charge you per page, according to the limits set by state law. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.
- **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
- **Amendments**: Health information should be amended as necessary. You should advise us when changes in your health occur.

QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us, or may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request. If you want more information about our privacy practices or have questions, please contact us.

I have received a copy of the Notice of Privacy Practices of Cleveland Smile Center LLC. This documentation will be placed on file.

SIGNATURE ____**DATE** ___________________________