SmileWorks
Daron Lind DDS
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(208) 846-8847

Welcome! We are pleased that you have chosen our office to care for your dental health. Please help us by taking a minute to provide us with a little information about yourself.

PATIENT INFORMATION **Date: _____**

Name: _____ Preferred Name: _____

Date of Birth: _____ SSN: _____ Sex: ___ Male_____ Female _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work #:_____

Marital Status: Married ____ Single ____ Divorced ____ Widowed ____ Other _____

Spouse's Name: _____ Emergency Contact No.:_____

Patients' Employer: _____ Employer Phone No.:_____

Email: _____

Whom may we thank for referring you to us?

Friend/Family/Patient: _____Website_____ Pharmacy: ____Portico _____ Fred Meyer

Elementary School: _____ Pepper Ridge _____Spalding

BILLING INFORMATION

Person Responsible for Payment: _____

Social Security No.:_____ Date of Birth: _____

Responsible Party's Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party's Home Telephone: _____ Business Telephone: _____

Responsible Party's Employer: _____

FINANCIAL POLICY

Your insurance is a contract between you, your employer, and your insurance company. Please note that you are responsible for making us aware of individuals covered by your policy, the procedures your insurance plan will cover, your deductible, the percentage covered by each procedure, and your annual maximum allowance. This information is contained in the insurance company booklet furnished to you upon enrollment for dental coverage. The type of treatment you need and receive from me is based on my professional judgment, expertise and training and your dental needs. I will not compromise what is best for my patients by diagnosing treatment needed based on an insurance company benefit plan.

Your estimated portion of the balance is due at the time of service unless prior financial arrangements have been made. While filing of insurance claims is a courtesy that we happily extend to our patients, all charges are your responsibility. There will be a finance charge on any balance outstanding 90 days after the completion of your dental treatment. This 90 day period allows time for insurance companies to respond and for us to let you know if there is any remaining balance due from you. After 90 days, any outstanding balance will be subject to a service charge of 3.00% per month (36% annually). **Returned checks are subject to a $20 accounting fee.**

We realize that temporary financial problems do arise, and we encourage you to contact us promptly for assistance in the management of your account. All financial arrangements must be made prior to a scheduled appointment. If no specific arrangement has been established, then full payment will be expected.

For your convenience, we accept payment by cash, check, or credit card. We accept Visa, MasterCard, and Discover. We also offer outside financing through Care Credit which give you the option of paying over 12 months with no interest.

If you have any questions about the above information, please do not hesitate to ask for our assistance. We are here to help you!

APPOINTMENTS

We value your time. We will do our best to stay on schedule so that you can be seen at your appointed time. In return, please be on time for the appointment as this time has been reserved just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us with at least **48 hour advance notice** so that we have the ability to find someone to take your place.
There will be a $25.00 charge for failed appointments. Initials: _____

AUTHORIZATION AND CONSENT

General Consent to Treatment: I agree and consent to a dental examination by Dr. Lind. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information: I authorize Dr. Lind to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other healthcare professionals.

Assignment of Insurance Benefits: I authorize and request my insurance company to pay my benefits directly to Dr. Lind.

Photography Release: I authorize Dr. Lind to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

Notice of Privacy Practices I acknowledge that I have the right to read the current "Notice of Privacy Practices" and know that a copy is available for me and will be given to me upon request.

Numbness following use of anesthesia: In preparation of teeth for crowns or bridges, anesthetics are usually needed. As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even a resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues that is usually temporary; in rare instances, such numbness may be permanent

_____ **Date:** _____

Signature of Patient, Parent or Guardian

Time 8:38 AM

Smile Works

Date 12/16/2015

Medical History to use

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs? Please list....	◯ Yes ◯ No	If yes
Are you taking a blood thinner?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Are you having any teeth sensitivity?	◯ Yes ◯ No	
Are you happy with your smile? What would you	◯ Yes ◯ No	
Circle if you have problems with any of the following: Bad Breath Bleeding Gums Clicking	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other Allergies ?	☐	If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Treatment	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Hepatitis	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Easily Winded	◯ 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
Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ 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	Kidney Problems	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ 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	Cancer	◯ Yes ◯ No	Glaucoma	◯ 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	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No				

Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

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:

X Date:_____

NOTICE OF PRIVACY PRACTICES

This Notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purpose permitted or required by law. It also describes your rights concerning your protected health information. **"Protected health information"** is information about you, including demographic information that may identify you and relates to your past, present and future physical or mental health or condition and related health care services. We are required by law to follow the practices described in this **Notice**.

You may obtain a copy of our Notice of Privacy at any time by calling our office or requesting one at your next appointment.

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example: we will disclose information to diagnose and /or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provided to you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct business activities of this office. These activities include but are not limited to quality assessment and improvement activities, review of the performance and qualifications of employee, evaluating practitioner and provider performances, conducting training programs, accreditation, certification licensing or credentialing activities.

We may also call you by name in the waiting room when we are ready to begin your treatment. **We may call to remind you of an appointment and if you are not available we may leave a message on your voice mail or with another member of your household.**

We will share your protected health information with business associates that perform specific functions for our practice such as billing.

Signature_____ Date:_____