

**Patient Information**

Name: \_\_\_\_\_ BirthDate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex  M  F  
 Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Soc. Sec #: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 How did you hear about our practice? \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible Party Information**
 **Check here for Self**

Name \_\_\_\_\_ BirthDate \_\_\_\_\_  
 Relation to Patient \_\_\_\_\_ Phone \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 Address (if different from patient's) \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

**Insurance Information**

Policy Holder's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ BirthDate \_\_\_\_\_  
 Insurance Company Name \_\_\_\_\_ Policy Holder's Employer's Name: \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_ Subscriber # \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Do you have secondary insurance?  Yes  No

**Medical History**

Do you have any general health problems?  Yes  No Please specify \_\_\_\_\_  
 Are you currently under physician's care?  Yes  No  
 Name and phone # of physician \_\_\_\_\_  
 Are you currently taking any drugs or medications?  Yes  No Please list \_\_\_\_\_

Are you allergic to:  Penicillin  Codeine  Latex  Other

Are you pregnant?  Yes  No Nursing?  Yes  No

Check X if you have or have had any of the following:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Blood Disorders       | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Prolonged Bleeding  |
| <input type="checkbox"/> Cortisone Treatments    | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Chemical Dependency   | <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis/Rheumatism    | <input type="checkbox"/> Chemotherapy          | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Scarlet Fever         | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Healing complications | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> High Blood Pressure     |  | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis        |

**Signature Of Patient/Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Dental History**

- What prompted you to seek dental care at this time? \_\_\_\_\_
- Has the fear of discomfort kept you from regular dental visits?.....  Yes  No
- When was your last dental appointment? \_\_\_\_\_
- How long since your last thorough examination with full mouth x-rays? \_\_\_\_\_
- Are your teeth sensitive to:  
**Heat?**  Yes  No    **Cold?**  Yes  No    **Sweets?**  Yes  No    **Biting Pressure?**  Yes  No
- Does food constantly get stuck between certain teeth in your mouth?.....  Yes  No
- Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc.     Yes  No
- Do your gums bleed while brushing?.....  Yes  No
- Do you ever avoid any part of the mouth while brushing?.....  Yes  No
- Have you been instructed regarding proper home care? .....  Yes  No
- Do you have an unpleasant taste or odor in your mouth? .....  Yes  No
- Do you smoke?.....  Yes  No
- Do you frequently snack between meals on sweets or chew gum?.....  Yes  No
- How often do you brush your teeth? \_\_\_\_\_
- How often do you floss? \_\_\_\_\_

**Remarks**

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**HIPAA OMNIBUS RULE**  
**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

*You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.*

**HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:**

First Name Only    Proper Surname    Other \_\_\_\_\_

**PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:**

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:**

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

**I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:**

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above              |

**I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of Mosaic Smiles via:**

- |  |  |
|--|--|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Text Message  |  |
| <input type="checkbox"/> Email         |  |

**The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.**

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

**In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.**

\_\_\_\_\_  
**Printed name of Patient**

\_\_\_\_\_  
**Signature of Patient / Guardian of Patient**

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**Guardian / Legal Representative**

\_\_\_\_\_  
**Signature of Patient / Guardian of Patient**

**Date:** \_\_\_\_\_

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- |  |       |
|--|-------|
| It was emergency treatment               | _____ |
| I could not communicate with the patient | _____ |
| The patient refused to sign              | _____ |
| The patient was unable to sign because   | _____ |
| Other (please describe)                  | _____ |

\_\_\_\_\_  
**Signature of Privacy Officer (Office Personnel)**



## Financial Policy

**Welcome!** Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Financial Policy. If you have any questions after reviewing our policy, please ask the receptionist.

**Insurance:** If you have dental insurance, we will gladly file your claim for you; however, you are responsible for your account. Insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing your benefits. Any amount that is not covered by your insurance is your financial responsibility.

**Payment Options:** In addition to Cash, Checks, Visa, MasterCard, Discover, and American Express we offer payment options-please see our financial coordinator for details. If payment is made with a check, and it is returned, you will be responsible for a \$35.00 returned check charge.

**Payment is due at the time of service. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.**

If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If your account becomes delinquent, it will be turned over to a local collection agency and you will incur any collection costs and any related attorney's fees.

We request **48 hour notice** if you are canceling an appointment. **If no attempt is made a \$50.00 cancellation fee will be assessed to your account.**

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Printed Name of Patient or Guardian:** \_\_\_\_\_