Welcome

TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

E-mail _____ Cell Phone #1 (____) _____ Cell Phone #2 (____) _____

Employer/School _____ Employer/School Phone (____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

- O V E R -

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between the teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia	☐ Congenital Heart Lesions	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cortisone Treatments	☐ Hernia Repair	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough, Persistent	☐ High Blood Pressure	☐ Skin Rash
☐ Artificial Joints, Pins, etc.	☐ Cough up Blood	☐ HIV/AIDS	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Jaw Pain	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Problems
☐ Bleeding Abnormally	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsilitis
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Super Smile Center

10320 Westlake Drive Suite #109
Bethesda, MD 20817
Office Number (301) 469-4775

PATIENT CONSENT REGARDING PAYMENT

Dentist:_____ Patient:_____

I, _____, understand and consent to the following:

1. I understand that I am financially responsible for all charges and that payment is expected as services are rendered. I will pay in full any cost of my or a dependent's treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover. I agree that any unpaid claims my insurance carrier does not pay or any balance that extends beyond 30 days from the date of treatment will be assessed a service charge of 2% per month.

2. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

3. I understand that Super Smile Center will assist with any insurance questions and will help me receive the maximum benefits available under my policy. I understand that no insurance covers all dental costs, and that it is my responsibility to pay any deductible, co-insurance, or any balance not paid by my insurance company. I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested. I understand that it is important that Super Smile Center has all of my correct information in order to ensure that my claim is processed timely and correctly.

4. I am aware that I will be responsible for any appointments cancelled or broken without a 24-hour notice. The charge for every cancelled appointment (without 24-hour notice) is $30. This fee is subject to change at the discretion of the Practice.

5. I am aware that I will be responsible for payment of a reasonable cost-based fee for the release of my medical records, not to exceed $0.76/page plus the actual cost of postage and handling. I am aware that I may request that these medical records be sent on to another provider and that I would be responsible for a preparation fee of $22.88, in addition to the costs mentioned above.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Signature of Patient/Legally Authorized Representative

Date

Printed Name

Relationship
(if signed on behalf of patient)

Signature of Dentist

Date

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Dear Patient,

Every effort is made to keep on schedule so we respectfully ask patients to be prompt in keeping their appointment. Our standard office policy regarding appointments is as follows:

We try to remind patients by telephone and email prior to their appointments but, please DO NOT depend on this courtesy. If we are unable to contact you, your appointment email will serve as the confirmation of your appointment and implies your obligation to be present. That time has been reserved specifically for you. If you need to change your appointment, please try to give our office at least 24 hours' notice so we can avoid lost appointment time.

NO CALL-NO SHOW POLICY:

Our office has a NO CALL-NO SHOW POLICY that we do enforce. Our time, like yours, is valuable. If you find that you cannot keep a scheduled appointment, please have the courtesy to call us and cancel. If you have incurred three NO CALL-NO SHOWS, our office will terminate the patient-provider relationship. We would be happy to provide your next dentist with your dental records at your written request.

If you have any questions or wish to inform us of some problem of which we may not have been aware of, please call.

Thank you for your future cooperation!

Amisha N. Shroff, D.D.S.

_____

Patient Signature

_____

Date

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10320 Westlake Drive Suite #109
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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Revocation
Date Revoked: _____
Initials of Privacy Official _____

Patient Name: _____ Dental Record No._____

Address: _____

I authorize Super Smile Center to use or disclose my health information as described below.

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

_____ The entire dental record (all information)	_____ Diagnostic reports (lab, x-ray, etc.)
_____ Activity documentation	_____ History and physical, other records
_____ Assessments, flow sheets	_____ Medication and treatment records
_____ Care Plan	_____ Orders
_____ Dentist and professional consult progress notes	_____ Social Services documentation
_____ Other: (Describe as specifically as possible).	

_____

_____

2. **Recipient of information** - The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

3. **Purpose of use/disclosure** - This information described on the previous page will be used for the following purpose(s):

____ Initiated at the request of the patient.

____ My personal records

____ Sharing with other healthcare providers as needed

____ Other (please describe):_____

Authorization Statements/Signatures:

4. I understand that after the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. For **Marketing disclosures only:** ***(Check if applicable)*** _____I understand that Super Smile Center will receive compensation related to the use or disclosure of the requested information.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Super Smile Center staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. Unless I specify differently, this authorization will expire (insert date or event):

_____

8. I understand that Super Smile Center will not condition the provision of treatment or payment on the provision of this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Distribution of copies: Original to patient's Dental Record, copy to patient.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Health Record No._____

Address:_____

I have been given a copy of Super Smile Center's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that Super Smile Center has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Official.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

File original in patient's chart.