WELCOME TO SMILESCAPES DENTISTRY

We are pleased to have you as a patient and want to assure you that we intend to do everything possible to ensure your comfort and confidence in our services. We strive to provide the highest quality care using only the very best, proven techniques and materials- while catering your ultimate relaxation in a pampering, nurturing environment.

Please begin by giving us some information about yourself and your current health, habits, and requirements for medications. This information is considered confidential.

Again, welcome to SmileScapes Dentistry!

Dr. Robert Woods & The SmileScapes Team

ABOUT YOU

First name: ____________________Middle initial: ____ Last name: ____________________Date:_________________

☐ Male ____ ☐ Female ____ ☐ Single ____ ☐ Married ____

Address: ____ City/State: _________________________Zip: ___________

Home Phone: ____________________________ Cell: _____________________________ Work: ___________________

Employer: _________________________________ Occupation: _____________________________ How long: _____

Date of Birth: _______________ Age: _______ Social Security# ________________________

Email Address: ____

How do you prefer to receive appointment reminders? ☐ Phone ☐ Email ☐ Text

How did you find us? ____

EMERGENCY:

Person to contact in case of emergency: _________________________Relationship: ____________________

Phone Number: _____________________

Responsible Party's Name (if under 18) ____________________

YOUR DENTAL HISTORY:

What is your immediate concern? ____

Is there anything about the appearance of your smile that you would like to change? ______________________

Previous Dentist: _______________________ City and State: ________________ Last Visit: _________________________

Date of Last Dental X-rays ___________ was treatment recommended: _______________________________________

Was treatment completed: ______________________________

How often do you brush? _______________ Floss? _________________ Use mouthwash? _______________________

Please check any of the following conditions that apply to you:

____ Bad Breath
____ Sensitivity to Hot/Cold
____ Mouth Sore or Growths
____ Jaw Clicking or Popping
____ Sensitivity when Chewing
____ Broken or Missing restoratio

Are you currently in any pain? ☐ Yes ☐ No

Have you ever been diagnosed with or treated for gum disease? ☐ Yes ☐ No

Have you ever been under the care of a Periodontist? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you ever have pain in the jaw joint? ☐ Yes ☐ No

Have you ever had a reaction to anesthesia? ☐ Yes ☐ No

Have you ever had complications after dental treatment? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Do you wear any type of removable dental appliance? ☐ Yes ☐ No

Do you currently, or have you ever had mouth piercings? ☐ Yes ☐ No

Would you like to speak to the Doctor privately? ☐ Yes ☐ No

Have you ever had Botox and/or dermal fillers before? ☐ Yes ☐ No

Would you be interested in learning more about eliminating facial wrinkles? ☐ Yes ☐ No

What is the **most** important thing to you when you consider your dental care and treatment?(select one)

____Appearance ____Longevity ____Function ____Comfort ____Health

Has fear ever been an issue for you in a dental office? _________________________

Has the cost of dental treatment been a concern for you? If yes, how can we help? ____________________________

____

YOUR MEDICAL HISTORY

Do you have a personal physician: ☐ Yes ☐ No Are you currently under the care of a physician ☐ Yes ☐ No

Physician name: ______________________ Physician phone number: ____________________

Under care of physician for (explain please):____
Do you take antibiotic premedication for your dental visits? If yes, please explain ___________________________

Your current health is: ☐ excellent ☐ good ☐ normal ☐ Poor Date of last physician visit: __________

Are you taking any prescription/over the counter drugs (please list all with condition for which you take them)?

____

ALL PATIENTS: Do you have a history of the following?

☐Yes ☐ No Anemia	☐Yes ☐ No Fainting	☐Yes ☐ No Jaundice
☐Yes ☐ No Cancer/chemotherapy	☐Yes ☐ No Cough, Persistent	☐Yes ☐ No Seizures/convulsions
☐Yes ☐ No Artificial joints	☐Yes ☐ No Kidney disease	☐Yes ☐ No Sinus problems
☐Yes ☐ No Artificial Heart Valve	☐Yes ☐ No Liver Disease	☐Yes ☐ No Shingles
☐Yes ☐ No Athlete's foot	☐Yes ☐ No Alcohol abuse	☐Yes ☐ No Sickle cell disease
☐Yes ☐ No Heart murmur	☐Yes ☐ No HIV Positive/ AIDS	☐Yes ☐ No Thyroid disease
☐Yes ☐ No High blood pressure	☐Yes ☐ No Abnormal bleeding	☐Yes ☐ No Steroid Therapy
☐Yes ☐ No Low blood pressure	☐Yes ☐ No Bursitis	☐Yes ☐ No Stroke
☐Yes ☐ No Headaches	☐Yes ☐ No Cough up blood	☐Yes ☐ No Heart attack
☐Yes ☐ No Mitral Valve Prolapse	☐Yes ☐ No Colitis	☐Yes ☐ No Heart disease/defect
☐Yes ☐ No Rheumatic Fever	☐Yes ☐ No Difficulty breathing	☐Yes ☐ No Hay Fever
☐Yes ☐ No Tuberculosis	☐Yes ☐ No Diabetes	☐Yes ☐ No Head or Neck Injury
☐Yes ☐ No Circulatory Problems	☐Yes ☐ No Eating disorder	☐Yes ☐ No Tumors
☐Yes ☐ No Cortisone Treatments	☐Yes ☐ No Herpes/ fever blisters	☐Yes ☐ No Hemophilia
☐Yes ☐ No Glaucoma	☐Yes ☐ No Mental disorders	☐Yes ☐ No Hepatitis
☐Yes ☐ No Arthritis	☐Yes ☐ No Epilepsy	☐Yes ☐ No Venereal disease
☐Yes ☐ No Rheumatism	☐Yes ☐ No Pacemaker	Other:
☐Yes ☐ No Chemical Dependency	☐Yes ☐ No Asthma	____________________

Do you use tobacco in any form? ☐Yes ☐ No Type: ______________ Frequency: ______________
Have you had any recent surgeries? ☐Yes ☐ No
Have you ever had a blood transfusion? ☐Yes ☐ No

Are you allergic to any of the following:

Yes No Aspirin	☐Yes ☐No Erythromycin
Yes No Novocaine	☐Yes ☐No Latex
Yes No Jewelry/Metal	☐Yes ☐No Tetracycline
Yes No Penicillin	Other: __________________
Yes No Codeine	

Are you aware that the health of your mouth has a direct effect on your overall health? ☐Yes ☐No
Are you pregnant or trying to get pregnant? ____

IMPORTANT INFORMATION FOR OUR PATIENTS

Dental Benefits

Policy holder's name: ______________________________ Employer: ____

Relation to patient: __________________________ Birth date: ___/___/____ Social Security Number: ____________________

Name of Insurance Company: ____

Policy #: ________________________ Group/Plan #: ________________________

Are you aware that you are responsible for any charges not paid by your insurance? ☐ Yes ☐ No

Dental Insurance:

We are happy to assist you with your dental insurance plan. To help us assist you in obtaining your maximum benefit, please present your insurance card at the start of your appointment. Once your plan coverage has been verified, we will accept assignment of payment from your insurance company. Most plans cover only a portion of the dental fee, which means you will be responsible for your deductible and the portion we estimate your plan will not cover. Payment of estimated portion is expected to be paid at the time you are in our office for dental care, unless prior arrangements have been made.

Please remember dental benefits help defray the costs of dental care and require patients to pay the portion of the fee that insurance does not cover. This is your co-payment. Dental insurance benefits pay based on the premium paid by you or your employer. Higher premium plans pay more of the fees for your dental care and have fewer exclusions and waiting periods. Dental insurance policies restrict payment for some services, use restricted fee schedules and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance.

We will recommend treatment appropriate to your dental needs regardless of your insurance status. At SmileScapes, we pride ourselves on providing the highest standard of care. Dr. Woods and his team are looking out for your health, first and foremost. Our primary goal is to maintain your dental heath!

Secondary Insurance:

We do not accept assignment of benefits on a secondary insurance. If you have a secondary insurance, we file your primary insurance for you. You are asked to pay anything that your primary insurance does not cover. We provide you with the necessary forms so that you can submit for reimbursement from your secondary carrier.

Payment Options:

For your convenience, we accept cash, Visa, MasterCard, AMEX, Discover and personal checks. Individual financial arrangements can be made to assist you with your budget.

Appointments:

Our appointments are scheduled to respect your time. You are reserving a specific time necessary to complete your care properly. We make every effort to see you at that appointment time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change your appointment, a 2 business day notice is requested so that we may offer the time you reserved to waiting patients. There is a $50 charge for broken or canceled appointments without a 2 business day notice.

Fees:

Fees for treatment are subject to change based on the rising costs of supplies and materials. We will honor fees for 90 days from the initial date of diagnosis and presentation. Prolonging your treatment may result in a higher cost to you.

I have read, understand, and agree to the above stated office policies.

Signature: ___________________________________ **Date:** _________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new 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 a significant change 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. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

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: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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.

Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may 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 safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
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 agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.)We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

I hereby acknowledge that I have read the Privacy Protection Policies for this office. I understand that I may ask any questions I may have in regards to this notice and receive a copy of it upon request.

Signature: ______________________________ Date: __________________

Waiver to consult with family members about your care and treatment

I hereby allow Dr. Woods and his clinical team to discuss my treatment and dental care with the members of my family listed below: (please include name and relationship)

____

____

Signature: ______________________________ Date: ______________________

Photo Release

Photos taken during treatment may be used to educate other patients, staff or doctors. Candid photos taken in our office for fun or special events are subject to being posted within the office or on our social media sites.

I give SmileScapes permission to use photos of me or my teeth for these occasions.

Signature: ______________________________ Date: ______________________

Thanks for your understanding and cooperation!

We promise to give you the most comprehensive dental care possible to contribute to your overall health and wellbeing. At SmileScapes, you're not just a patient, but part of our family!

The information that I have provided is accurate and truthful to the best of my knowledge and I acknowledge that I have read and understand the stated and described practice policies.

Signature of patient, parent or guardian: ____ Date: ________________