Smile Solutions
DENTISTRY
Nirav Patel, DMD

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach exceptional oral care that will enable you to have a beautiful smile that lasts a lifetime.

Today's Date _____

Patient Information

First Name _____**MI**_____

Last Name _____

Birthdate_____ **Age**_____ **SS#**_____

Address _____

_____

Home # _____ **Cell #** _____

Employer _____**Work #** _____

Occupation _____

Email _____

Referred by _____

Emergency Contact Name: _____

Emergency Contract Phone # _____

Responsible Party

(Skip if same as above)

First Name _____**MI**_____

Last Name _____

Birthdate_____ **Age**_____ **SS#** _____

Employer _____**Work #** _____

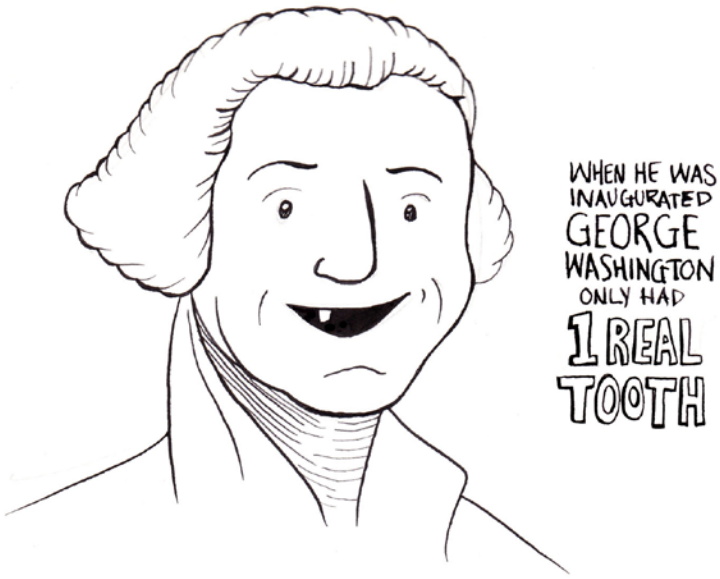
Occupation _____

Employer's Address _____

Teeth are always in style.

~ Dr. Seuss

Primary Dental Insurance



Insurance Co. Name _____

Insurance Co. Phone _____

Group # _____**Policy #** _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ **SS#** _____

Policy Owner's Employer _____

Employee's Address _____

_____

Dental History

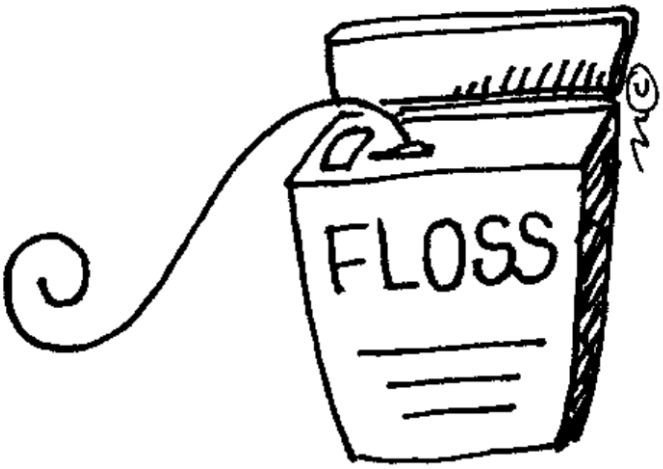
Purpose of today's visit _____

Previous Dentist _____

Date of last visit _____

What was done _____

Last Cleaning _____



Medical History

Physician _____ **Date of Last Visit** _____

Address _____ **Phone** _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems
Anemia	Pneumonia Dizziness	Herpes
Arthritis	Prolonged Bleeding Epilepsy	High Blood Pressure
Asthma or Hayfever	Radiation/Chemotherapy Gastrointestinal Disorders	HIV / Aids
Bone Disorders	Rheumatic Fever Heart Problems	Kidney problems
Congenital Heart Defect	Tuberculosis Heart Murmur	Nervous Disorders
Tumor or Cancer		

Medical conditions we have not discussed that you feel we should be aware of? _____

_____

Signature of Patient or Responsible Party **Date**

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received and reviewed a copy of **Smile Solutions Dentistry**'s *HIPAA Notice of Privacy Practices*.

I understand that **Smile Solutions Dentistry**'s *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Smile Solutions Dentistry**'s revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about **Smile Solutions Dentistry**'s *HIPAA Notice of Privacy Practices*, I may contact Dr Patel at (561) 530 3764.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Smile Solutions Dentistry** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Smile Solutions Dentistry**'s privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask our front desk Manager, for assistance.

_____

Signature of Patient or Responsible Party **Date**

Smile Solutions Dentistry Financial Policy

INSURANCE: Your insurance policy is a contract between you and your insurance company. Insurance policies vary, even within the same company. As a courtesy to our patients, we will submit insurance claims directly to your insurance carrier. We can estimate and will assist you in determining your insurance benefits. Any uninsured portion is due at the time of service. If for any reason, the estimated amount is not paid by your insurance company, you will be responsible for the unpaid balance.

We encourage you to overview your policy in detail so that you are aware of your plan specifics and maximum coverage. All questions about your coverage should be directed to your insurance company.

NON-INSURED SERVICES and EMERGENCY SERVICES: Payment in full is required at time of service.

We fully believe dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we do provide a number of payment options.

MISSED APPOINTMENTS: Our practice is dedicated to providing exceptional care for our patients, every appointment. We respect the importance of your time and work very hard to schedule appointments that accommodate the scheduling needs of our patients. In order to best serve all of our patients, cancellation fees of **$50** per hour are charged for missed appointments or appointments cancelled without 24 hours notice. We appreciate your cooperation.

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and understand that **15% interest** will be applied annually to any outstanding balances of 90+ days. I authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if she so determines. I consent to the taking of **photographs and x-rays** before, during and after treatment, and to the use of same by the doctors in scientific papers or demonstrations. I certify that I have read or had read to me the contents of this form and financial policy, and do realize the risks and limitations involved.

_____

Signature of Patient or Responsible Party **Date**