Welcome!

**We want to first *thank you* for choosing our team to take care of you and your family!**

We respect that your time is busy and valuable! We reserve time slots for our patients’ months in advance and we take our patient care and experiences extremely seriously. We prepare for you before you are here **to make sure you have a timely and amazing experience every time**.

We ask for your mutual respect for our time. Our office policy is to **confirm your appointment at least 24-48 hours in advance**. We utilize email and text messaging prior to calling for your convenience, if an automated attempt is made and no response is given, we will call to confirm. Once a response is given, you will not be contacted further until 2 hours prior to your appointment time.

If you are unable to make it to an appointment, we understand. As a courtesy to our time, **we request a 24-hour call or text prior to your appointment to cancel**.

If a minimum of 24-hours is not given we will enforce a $50.00 cancellation fee for each appointment cancelled or missed. For patients with Texas Medicaid & Healthcare Partnership insurance, we will report every offence of a missed appointment.

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I have read and understand The Smile Spot confirmation and cancellation policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name – or guardian of minor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

patient or guardian signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**New Patient Form**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Name, First Name MI. Preferred Name

**Title:** Mr./Ms./Mrs./Etc. **Gender:** Male/Female **Family Status:** Married / Single / Child / Other

**Birth Date:** \_\_\_/\_\_\_/\_\_\_ **SS#:** \_\_\_\_-\_\_\_-\_\_\_\_\_ **DL#:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ **Best Time to Call:** \_\_\_\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State** \_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_

**Primary Language:** English / Spanish / Arabic / Vietnamese / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian (If Applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about our dental office?** Insurance / Friend / Relative / Employee / Social Media / Internet / Other: \_\_\_\_\_\_\_\_\_\_\_

**Patient Insurance / Payment Responsibility**

**Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance Co. Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date:** \_\_\_/\_\_\_/\_\_\_

**Plan ID#/Policy Holder’s SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder’s Address** (if different from patient)**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder’s Phone Number** (if different from patient)**:** \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** Self / Spouse / Child / Other

Is there a secondary insurance? YES / NO

**Secondary Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance Co. Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date:** \_\_\_/\_\_\_/\_\_\_

**Plan ID#/Policy Holder’s SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder’s Address** (if different from patient)**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder’s Phone Number** (if different from patient)**:** \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** Self / Spouse / Child / Other

By signing below, I understand that any prices given to me by The Smile Spot are an estimate based on information given from my insurance company, any amount not paid by my insurance company / companies will become my responsibility. It is my responsibility to know and understand my insurance coverage and limitations, and to ensure I am covered on the day of my dental visit. I understand that if I have a secondary insurance, there is no guarantee they will pay the full estimated amount. I have answered all the information to the best of my knowledge and ability. If there are any changes to my insurance, health or medication, I will alert the dental office as soon as possible.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Parent / Guardian Signature Date

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**Please circle any/all of the following conditions you have or have had in your lifetime:**

 ADD/ADHD Glaucoma Rheumatism Tuberculosis Cancer / Chemo

 Asthma AIDS/HIV Seizure/Epilepsy Anemia / Hemophilia Scarlet Fever

 Autism Pacemaker Thyroid Disease Kidney Problem Emphysema

 Hepatitis Diabetes Osteoporosis Heart Disease / Attack / Murmur

 High Blood Pressure Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle any of the following you are allergic to:**

Amoxicillin Aspirin Hay Fever Anesthetic / Lidocaine

 Clindamycin Erythromycin  Latex Barbiturates / Sedatives / Sleeping Pills

 Penicillin Codeine Sulfa Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently seeing a medical physician?** YES / NO

If yes, please explain why/the condition being treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you taking any medication? YES / NO**

If yes, please list the medication, dosage and reason for taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke?**  YES, \_\_\_\_\_\_ / day NO **Do you use recreational drugs?** YES / NO

**Are you pregnant?** YES, \_\_\_\_\_ / mo. NO N/A **If yes, did you bring a clearance?** YES / NO

**Reason for today’s visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you nervous about dental treatment?** YES / NO

**Do your gums bleed/feel irritated?** YES / NO

**Are your teeth sensitive to any of the following?** Hot / Cold / Sweets / Pressure

**Are you happy with the overall appearance of your teeth?** YES / NO

* If no, please explain why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have answered the above information to the best of my knowledge. If there are any changes to my / the patient’s health or medication, I will inform the office as soon as possible.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Parent / Guardian Signature Today’s Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dr Weight Date**

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**HIPAA ACKNOWLEDGEMENT CONSENT OF DISCLOSURE**

(For the Usage and or Disclosure of Protected Health Information)

**THE SMILE SPOT PRIVACY AND CONSENT**

1. I authorize the doctor/staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my/the patient’s dental needs.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor/staff, and to use the appropriate medication and therapy indicated for such treatment.
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor can choose and employ such assistance as deemed fit to provide recommended treatment.
4. I have answered all the above questions to the best of my knowledge. If there have been any changes to my insurance, health or medication, I have and/or will inform my dentist during my next appointment.

I, the undersigned, hereby authorizes that I have read, understand and agree to the above conditions.

I hereby give consent to **THE SMILE SPOT** to use and disclose my protected health information for treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed and delivered to the address below. You may deliver this in person or by mail but it will only be effective when we receive it.

You have the right to request restriction on the usage and disclosure of your health information for the purpose of treatment, payment or health care operations. We are not required to grant your request, however if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure for your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy be requesting it from the front desk staff.

I have had an opportunity to review the Notice of Privacy Practices.

Print Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print your Name (If different from the patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** Self / Spouse / Child / Other

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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