KIRBYSMILES
FAMILY | COSMETIC | SEDATION

Patient Registration Form

Welcome to Kirby Smiles! We know how important it is to feel comfortable and confident with your choice of dental care providers. We can assure you that we will take the time to listen to your needs and do the best we can to provide quality dentistry in a relaxed, family-oriented environment with a commitment to your overall oral health. Please fill out our patient registration forms as completely as possible so that we may get to know you better and provide you and your family the best care. All information contained within these forms is confidential.

Primary Patient Information -Please Print

Name _____ DOB _____Age_____ SS# _____

Address _____City _____ State ____Zip_____

Email _____Cell Phone _____ Home Phone_____

Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Spouse Name _____Cell Phone _____

Person to contact in case of Emergency _____Cell Phone _____

Dependent _____ DOB _____ SS# _____

Dependent _____ DOB _____ SS# _____

Signature of Patient/Parent/Guardian _____ Date _____

Responsible Party

Self (same as above) □Yes □ No

Name of Person Responsible for this account _____ Relationship to Patient _____

Address _____City _____ State _____ Zip_____

DOB _____ SS# _____ Phone _____

Is this person currently a patient in our office? □Yes□ No Signature of Patient/Parent/Guardian _____

Primary Insurance Information

Name _____ DOB _____ SS# _____

Employer_____ Employer's Phone #_____

Employer Address _____

Insurance Company _____Insurance Phone #_____

Insurance Address_____

ID Number _____ Group/Policy Number _____

Who can we thank for your visit with us today? _____

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Financial Policy

We are privileged you have chosen us as your dental care provider. We are committed to providing you and your family with the highest quality of dental care. In order to enhance communication and promote understanding regarding our office's financial policy, please read the following information. This must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please speak with our patient care coordinator.

- I understand that I am responsible for payment of all products and services provided to me or my dependents by Kirby Smiles.
- I understand I may be charged a $50 fee for any no call/no show/missed appointment without 48 hours advance notice.
- I understand that consistently broken appointments will require a credit card reservation in order to secure my next appointment.
- I understand that deposits may be required to secure appointment times for periods longer than one hour.
- For larger cases, 50% of the patient portion is due at the start of treatment, including any deductible and the remaining 50% at the last appointment.
- I understand that if I decide to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with our patient care coordinator.
- I understand I will be charged a $35 processing fee per each returned check.
- I understand there may be a 1.5% per month finance charge on all accounts over 30 days past due.
- I understand if my account is not paid within 90 days of treatment it may be turned over to a collection agency or the office attorney and I will be responsible for all collection fees and court costs associated with my delinquent account.
- Full payment is due at the time of service. We gladly accept most major credit cards, checks and cash unless prior financial arrangements have been made for qualified individuals with Kirby Smiles.
- Regarding insurance: your insurance policy is a contract between you, your employer and the insurance company. We have no control over their decisions and the amount they decide to pay. Our financial relationship is with you, not your insurance company. However, as a courtesy to our patients, we will file your primary insurance claims for you. We will not file any secondary insurances. Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. Regardless of what your insurance company pays, you are ultimately fully responsible for the cost of services rendered by Kirby Smiles.

I have read and understand the above Financial Policy for Kirby Smiles. By signing below, I acknowledge responsibility and agree to the terms listed above.

Signature of Patient/Parent/Guardian_____**Date** _____

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Release and Assignment

I give this office permission to take images of my teeth, mouth and face and use them to aid in educational purposes, treatment planning and submission to insurance companies to help the patient get reimbursement and treatment approval, using both electronic and paper images, as needed and requested by the insurance companies. **Signature**: _____ **Date:** _____

I understand that Insurance is a contract between myself and my insurance company. Insurance is filed as a courtesy to patients of this office. Insurance estimates are estimates only. Although this office will do its best to help, this office will not be involved in insurance disputes.

This office follows the ADA, Texas, and Federal recommended document retention Guidelines. These guidelines are available upon request.

HIPAA Consent Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practice: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: you will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contract person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue to treat you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and the notice of privacy practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities, and health care operations.

Signature _____**Date** _____

If this consent is signed by a personal representative, parent or guardian on behalf of the patient, complete the following:

Personal Representatives Name_____ **Relationship to Patient** _____

Photo Release/Social Media Consent

I, _____, hereby grant and authorize Kirby Smiles the right to take, edit, post, publish, and make use of any and all pictures and video taken of me (or child if under 18) to be used in and or for legally promotional materials, but not limited to ,websites, social networking sites without payment or any other consideration. This authorization extends to all languages, media formats, now known or hereafter devised. This authorization shall continue indefinitely, unless I otherwise revoke said authorization in writing.

Signature_____**Date**_____

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Dental Health Questionnaire

Print Last **First** **Middle** **Nickname** **Date**

Accurate answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care most appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ☐ Yes ☐ No
2. Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No
3. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
4. Date of last dental visit? _____ Previous Dentist name _____
5. Have you ever been treated for periodontal disease (gums, pyorrhea, or trench mouth)? ☐ Yes ☐ No
6. How often do you brush? _____ Brush is: ☐ Soft ☐ Medium ☐ Hard
7. Do you have or have you ever had any of the following:

MOUTH			TEETH		
Bleeding, sore gums	☐ Yes ☐ No		Loose Teeth		☐ Yes ☐ No
Unpleasant taste/bad breath	☐ Yes ☐ No		Sensitive to hot		☐ Yes ☐ No
Burning tongue/lips	☐ Yes ☐ No		Sensitive to cold		☐ Yes ☐ No
Frequent blisters, lips/mouth	☐ Yes ☐ No		Sensitive to sweets		☐ Yes ☐ No
Swelling/lumps in mouth	☐ Yes ☐ No		Sensitive to biting		☐ Yes ☐ No
Ortho treatment (braces)	☐ Yes ☐ No		Food Impaction		☐ Yes ☐ No
Biting cheeks/lips	☐ Yes ☐ No		Clenching/grinding		☐ Yes ☐ No
Clicking/popping joint	☐ Yes ☐ No		When?	☐ Night ☐ Day ☐ Both	
Difficult opening or closing jaw?	☐ Yes ☐ No		Shifting in bite		☐ Yes ☐ No
			Change in bite		☐ Yes ☐ No

8. Do you use the following?

Brush	☐ Yes ☐ No	Dental Floss	☐ Yes ☐ No
Fluoride Rinse	☐ Yes ☐ No	Other:	_____

Check One:

1. My Mouth Is: ☐ very comfortable ☐ moderately comfortable ☐ uncomfortable
2. I ☐ think the appearance of my mouth is excellent
   ☐ am satisfied with appearance of my mouth
   ☐ am dissatisfied with the appearance of my mouth
3. I ☐ will do anything to keep my natural teeth
   ☐ want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them
4. I ☐ have set goals for my oral health with a previous dentist ☐ want to set goals concerning my dental health
5. I ☐ have always done the best that was recommended for my dental health
   ☐ have not done what dentists have recommended to me
   ☐ rarely go, and don't care much about having any dental work completed
6. I ☐ have put dentistry for myself and family high on my priority list
   ☐ put dentistry for myself and my family low on my priority list
   ☐ Dentistry is on my list but it's hard to find
7. I Think my present state of dental health is: ☐ Excellent ☐ Good ☐ Poor

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Dental Health Questionnaire Cont.

1. The most important concerns regarding my dental treatment are _____
2. What factors are most important for our satisfaction with our office? _____
3. What are some questions about dentistry and oral health that you have never had adequately answered? _____
_____
4. Any additional concerns/comments? _____

If child/minor: Please answer the following questions:

Any mouth habits? (thumb sucking/tongue thrusting/nail biting/mouth breathing/nursing or bottle habits/pacifier)
_____
Do you help your child with brushing and flossing and how often? _____

DENTAL HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I CERTIFY THAT THE ANSWERS TO THE HEALTH QUESTIONS ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE OF MEDICAL CONDITION OR MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT. I UNDERSTAND THAT THE ADMINISTRATION OF LOCAL ANESTHETIC MAY CAUSE AN ADVERSE REACTION OR SIDE EFFECTS, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO BRUISING, HEMATOMA, CARDIAC STIMULATION, TEMPORARY OR RARELY, PERMANENT NUMBNESS, AND MUSCLE SORENESS. I UNDERSTAND THAT AS A RESULT OF DENTAL TREATMENT, INCLUDING PREVENTATIVE PROCEDURES SUCH AS CLEANING AND BASIC DENTISTRY, AS WELL AS FILLINGS OF ALL TYPES, TEETH MAY REMAIN SENSITIVE OR EVEN POSSIBLY QUITE PAINFUL BOTH DURING AND AFTER COMPLETION OF TREATMENT. GUMS AND SURROUNDING TISSUES MAY ALSO BE SENSITIVE OR PAINFUL DURING AND OR AFTER TREATMENT.

CONSENT FOR TREATMENT: I HEREBY GRANT AUTHORITY TO THE DENTIST AT KIRBY SMILES TO ADMINISTER ANY TREATMENT OR TO ADMINISTER SUCH ANESTHETICS, ANALGESICS, SEDATIVES AND NITROUS OXIDE SEDATION, AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN MY DIAGNOSIS AND TREATMENT. I HAVE READ THE ABOVE TERMS AND CONDITIONS AND CONSENT FOR TREATMENT AND FULLY AGREE TO THEIR CONTENT. I DO VOLUNTARILY ASSUME ANY AND ALL POSSIBLE RISKS, INCLUDING THE RISK OF SUBSTANTIAL AND SERIOUS HARM, IF ANY, WHICH MAY BE ASSOCIATED WITH GENERAL PREVENTATIVE AND OPERATIVE TREATMENT PROCEDURES IN HOPES OF OBTAINING THE POTENTIAL DESIRED RESULTS, WHICH MAY OR MAY NOT BE ACHIEVED, FOR MY BENEFIT.

_____

SIGNATURE OF PATIENT/GUARDIAN **DATE** **RELATIONSHIP TO PATIENT**

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Medical Health Questionnaire

Patient's Name: _____ **Date of Birth:**_____

- Describe your general health._____
- Has there been any changes in your health in the past year?_____
- Are you currently under the care of a physician. If so, please explain:_____
- Have you ever been hospitalized or had major surgery/operation. If so, please provide details and dates._____

  _____
- Have you ever taken bone density medications such as Fosamax, Boniva, Actonel or any additional medications containing bisphosphonates? If so, please explain:_____
- Please list your current medications:_____
- Are you taking any controlled substances? If so, please explain._____
- Do you use tobacco in any form? If so, please explain._____

Do you have or have you had any of the following? (Please circle Y or N):

AIDS/HIV Positive	Y	N	Genital Herpes	Y	N	Peripheral Neuropathy	Y	N
Alzheimer's Disease	Y	N	Glaucoma	Y	N	Prostate Enlarged	Y	N
Anaphylaxis	Y	N	Hay Fever/ Seasonal Allergies	Y	N	Psoriasis	Y	N
Anemia	Y	N	Heart Attack/ Failure	Y	N	Pulmonary Embolism	Y	N
Angina	Y	N	Heart Murmur	Y	N	Psychiatric Care	Y	N
Arthritis/ Gout	Y	N	Heart Pacemaker	Y	N	Radiation Treatments	Y	N
Artificial Heart Valve	Y	N	Heart Disease	Y	N	Recent Weight Loss	Y	N
Artificial Joint	Y	N	Hemophilia	Y	N	Reflux Esophagitis	Y	N
Asthma/ RAD	Y	N	Hepatitis A	Y	N	Renal Dialysis	Y	N
Blood Disease	Y	N	Hepatitis B or C	Y	N	Renal Failure	Y	N
Blood Transfusion	Y	N	High Blood Pressure	Y	N	Rheumatoid Arthritis	Y	N
Breathing Problems	Y	N	High Cholesterol	Y	N	Rheumatic Fever	Y	N
Bruise Easily	Y	N	Hives or Rash	Y	N	Scarlet Fever	Y	N
Cancer	Y	N	Hypoglycemia	Y	N	Shingles	Y	N
Chemotherapy	Y	N	Irregular Heartbeat	Y	N	Sickle Cell Anemia	Y	N
Chest Pains	Y	N	Kidney Problems	Y	N	Sinusitis (Chronic)	Y	N
Cold Sores/Fever Blisters	Y	N	Kidney Stones	Y	N	Sleep Apnea	Y	N
Congenital Heart Disorder	Y	N	Leukemia	Y	N	Spina Bifida	Y	N
Convulsions	Y	N	Liver Disease	Y	N	Stomach/GI Disease	Y	N
Cortisone Medicine	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Diabetes	Y	N	Lung Disease	Y	N	Swelling of Limbs	Y	N
Drug Addiction	Y	N	Lupus	Y	N	Thalassemia	Y	N
Easily Winded	Y	N	Lyme Disease	Y	N	Thyroid Disease	Y	N
Emphysema	Y	N	Mitral Valve Prolapse	Y	N	Tinnitus	Y	N
Epilepsy or Seizures	Y	N	Menopause	Y	N	Tonsillitis	Y	N
Excessive Bleeding	Y	N	Multiple Sclerosis	Y	N	Tuberculosis	Y	N
Excessive Thirst	Y	N	Osteoporosis	Y	N	Tumors or Growths	Y	N
Fainting Spells/Dizziness	Y	N	Pain in Jaw Joints	Y	N	Ulcers	Y	N
Frequent Cough	Y	N	Parathyroid Disease	Y	N	Venereal Disease	Y	N
Frequent Headaches	Y	N	Parkinson's Disease	Y	N	Yellow Jaundice	Y	N

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Medical Health Questionnaire Cont.

- Is there anything important about your medical condition we have not listed above or asked? If so, please explain.
  _____

- Are you ALLERGIC to any of these below and what type of reaction? (Check all that apply):

o NONE
o Acrylic
o Anesthetic-Local
o Aspirin
o Codeine
o Latex
o Metal Sensitivity
o Nitrous Oxide Sedation
o Penicillin/Other Antibiotics
o Sulfa Drugs
o Tape
o Other _____

- For Female Patients:

Are you pregnant?	Y	N
Are you trying to get pregnant?	Y	N
Are you nursing?	Y	N
Are you taking oral contraceptives?	Y	N

- **Preferred Pharmacy/Address/Phone Number**_____
  _____

MEDICAL HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I CERTIFY THAT THE ANSWERS TO THE HEALTH QUESTIONS ABOVE ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT'S) HEALTH. SINCE A CHANGE OF MEDICAL CONDITION OR MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

_____

SIGNATURE OF PATIENT/GUARDIAN **DATE** **RELATIONSHIP TO PATIENT**

_____

WITNESS **DATE**

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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 our health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on 04/06/2019, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such charges 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 significant changes 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 practitioners and provider performance, conducting training programs, accreditations, certifications, 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.

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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 payments for 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 and safety of others.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____ have read and understand this office's Notice of Privacy Practices.

Printed Name:_____
Signature:_____
Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please specify):_____

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Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request treatment plans, diagnostic results, and/or financial information. Under the requirements for HIPPA, we are not allowed to give this information to anyone without patient consent.

If you wish to have your dental health information, any treatment plans, and/or financial information released to any family members, you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Kirby Smiles to release my records and any information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

_____

Patient Name (PLEASE PRINT) **Patient Signature** **Date**

Thank you for your time and

WELCOME to KIRBY SMILES!