TOUCH OF SMILES DENTAL CARE, LLC
50 Scott Adam Road Suite 100 Cockeysville MD 21030 (410) 628–1818 fax (410) 628–1828

TODAY'S DATE: _____

PATIENT INFORMATION

Legal Name: _____ **Preferred Name:** _____

SSN: _____ **Driver's License/ID #:** _____

****IN ORDER TO PROPERLY IDENTIFY OUR PATIENTS AND PREVENT INSURANCE FRAUD, THIS OFFICE REQUIRES A PICTURE IDENTIFICATION FOR ALL PATIENTS****

Sex: ☐ **MALE** ☐ **FEMALE** **Date of Birth:** _____

Marital Status: ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED**

Address: _____

_____

Home Phone #: _____ **Cell Phone #:** _____

****APPOINTMENT REMINDERS, INCLEMENT WEATHER UPDATES, AND OTHER IMPORTANT INFORMATION REGARDING YOUR APPOINTMENTS ARE SENT VIA TEXT MESSAGE. PLEASE BE SURE TO PROVIDE A CELL PHONE NUMBER****

E-mail Address: _____

Employer: _____ **Occupation:** _____

Business Address: _____

Business Phone #: _____ **Extention:** _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN THE PATIENT)

Name: _____ **Relationship to Patient:** _____

Phone #: _____

Address: _____

EMERGENCY CONTACT INFORMATION

In case of an emergency, whom may we notify?

Name: _____ **Relationship to Patient:** _____

Phone #(s): _____

HOW DID YOU HEAR ABOUT TOUCH OF SMILES DENTAL CARE?

Whom may we thank for referring you? _____

PRIMARY DENTAL INSURANCE INFORMATION (IF ANY)

Policy Holder Name: _____ **Date of Birth:** _____

Relationship to Patient: ☐ **SELF** ☐ **PARENT** ☐ **SPOUSE** ☐ **OTHER:** _____

Employer's Name: _____ **Phone #:** _____

Insurance Company Name: _____ **Phone #:** _____

Identification #: _____ **Group #:** _____

SECONDARY DENTAL INSURANCE INFORMATION (IF ANY)

Policy Holder Name: _____ **Date of Birth:** _____

Relationship to Patient: ☐ **SELF** ☐ **PARENT** ☐ **SPOUSE** ☐ **OTHER:** _____

Employer's Name: _____ **Phone #:** _____

Insurance Company Name: _____ **Phone #:** _____

Identification #: _____ **Group #:** _____

DENTAL HEALTH HISTORY

Reason for today's visit: _____

Previous Dentist's Name: _____ **Phone #:** _____

Location: _____

Date of last dental exam: _____ **Date of last dental x-rays:** _____

Please indicate if you have had a problem with any of the following conditions:

☐ Bad breath ☐ Grinding teeth ☐ Hot/cold sensitivity ☐ Bleeding gums ☐ Loose teeth ☐ Sensitivity to sweets
☐ Clicking/popping jaw ☐ Broken fillings ☐ Sensitivity to biting ☐ Food collection between teeth
☐ Gum inflammation ☐ Other: _____

How often do you floss? _____

Are you thinking about changing the overall appearance of your teeth? ☐ **YES** ☐ **NO**

If so, how? _____

MEDICAL HEALTH HISTORY

It is imperative that you complete this section to the best of your knowledge. Your medical health history, combined with information gathered during today's examination, will help to assess your immediate dental care needs and recommend the best treatment options.

Physician's Name: _____ **Phone #:** _____

Location: _____ **Date of last visit:** _____

Previous hospitalizations, illnesses, or operations:

_____

Has your physician ever told you to be premedicated with antibiotics prior to any dental treatment? ☐ **YES** ☐ **NO**

Are you pregnant? ☐ **YES** ☐ **NO** **Nursing?** ☐ **YES** ☐ **NO** **Taking birth control?** ☐ **YES** ☐ **NO**

Please indicate if you have, or have ever had, any of the following conditions:

☐ Aids	☐ Cortisone treatments	☐ Hepatitis	☐ Respiratory Disease
☐ Anemia	☐ Cough, persistent	☐ High blood pressure	☐ Rheumatic Fever
☐ Arthritis	☐ Coughing blood	☐ HIV	☐ Shortness of breath
☐ Artificial joints	☐ Diabetes	☐ Jaw pain/clicking	☐ Skin rash
☐ Asthma	☐ Fainting	☐ Liver disease	☐ Swelling of feet/ankles
☐ Back problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid problems
☐ Blood disease	☐ Nervous problems	☐ Tobacco habit	☐ Tonsilitis
☐ Cancer	☐ Heart murmur	☐ Pacemaker	☐ Tuberculosis
☐ Chemotherapy	☐ Heart problems	☐ Psychiatric care	☐ Venereal disease
☐ Circulatory problems	☐ Radiation treatment	☐ Ulcers	☐ Headaches
☐ Hemophilia	☐ Use of recreational drugs		

Please list any medications you are currently taking:

_____

_____

Please list all known allergies: _____

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any changes in my health status should occur.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

PAYMENT METHODS/POLICY

- **PAYMENT IS DUE AT THE TIME OF SERVICE.** If you have dental insurance, you will be responsible for your *estimated* co-payment and deductible (if any) **at the time of service**. If you do not have dental insurance, you will be responsible for payment in full at the time of service. Should you not be prepared to pay your entire balance at the time of treatment, please advise the staff PRIOR to your appointment. **Touch of Smiles Dental Care does not bill patients for co-payments.**
- **In the event that your insurance company does not pay the amount estimated for services rendered resulting in a balance on your account, you will be asked to pay the balance prior to your next visit. Please be prepared to do so.**
- Accounts with balances over 90 days old will be turned over to a collection agency. A $35.00 collection fee will be added to the account and is the patient's responsibility.
- Touch of Smiles Dental Care accepts cash, checks, money orders, and all credit cards for payment. **Post-dated checks will NOT be accepted and returned checks will result in a fee of $35.00 added to your account.**
- **REFUNDS :** Any refunds made following a credit card transaction will result in a **1.97% charge PER TRANSACTION.** This amount will be deducted from your refund.
- **For larger payments, third party financing through Care Credit, the Lending Club, or Lending USA may be available to you through this office.** Please speak with the Office Manager for more information regarding these options.

APPOINTMENT CANCELLATION POLICY

Your appointment time is reserved exclusively for you. Any change in your appointment affects many patients, thus, **a 24 hour notice is required to cancel or change your appointment. Anything less than a 24 hour notice is subject to a $35.00 broken appointment charge to your account. Saturdays are open by appointment only, thus a $70.00 charge will apply to any broken Saturday appointment.** Appointment reminders are given as a COURTESY via text message. It is the patient's responsibility to make and keep their appointment regardless of reminders, as it is the patient's responsibility to keep their cell phone number up-to-date with the office. **IF YOU RECEIVE A CHARGE FOR A BROKEN APPOINTMENT, YOU WILL BE ASKED TO PAY THE BALANCE BEFORE SCHEDULING ANOTHER APPOINTMENT.**

RELEASE OF RECORDS POLICY

The treating dentist has ownership of dental records and radiographs. In order to obtain a copy of your dental records and/or x-rays, or to transfer them to another dental office, **you must complete a records release form and pay an administrative fee of $0.79 per page, plus the cost of postage.** Records are sent via postal mail **only**. Once payment is received, it will take 24-48 hours to copy and mail your records.

INSURANCE AND PAYMENT AUTHORIZATION

- I understand and agree that I am fully responsible for providing Touch of Smiles Dental Care with **current** dental insurance policy information and informing the office immediately of any changes in my employment which may affect my dental insurance coverage. I understand that my policy must remain **active** during the **entire course** of my treatment in order for benefit estimate to be accurate.
- I understand and agree that I am fully responsible for any and all dental expenses incurred at Touch of Smiles Dental Care **regardless of estimated insurance benefits.**
- I understand that my dental insurance is a contract between the insurance company and myself. As a **courtesy**, Touch of Smiles Dental Care will submit claims to my insurance company on my behalf. Regardless of any third party or insurance involvement, I am ultimately responsible for payment of all dental fees.
- I authorize payment of any dental benefits issued by my insurance company directly to Touch of Smiles Dental Care.
- I authorize the release of all information necessary to secure payment of benefits.
- I agree to pay all attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.
- I have read and understand all of the above information.

PATIENT/GUARDIAN SIGNATURE:_____DATE:_____

GENERAL DENTISTRY INFORMED CONSENT

Please initial that you have **READ** the following. **Should you require any of the following procedures, there will be an additional consent form to be completed before treatment.**

_____ **EXAMS & DIAGNOSTIC PROCEDURES:** I understand that in order to determine my oral health and necessary dental treatment, the dentist will need to perform an examination and, in most cases, take dental x-rays.

_____ **PROPHYLAXIS (DENTAL CLEANING):** I understand that, based on the examination and/or dental x-rays, the dentist will determine whether I need a prophylaxis (regular dental cleaning) or a more extensive periodontal cleaning. The cost for each is not the same.

_____ **DRUGS & MEDICATION:** I understand that antibiotics, analgesics and other medications may cause an allergic reaction resulting in redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that the administration of local anesthetics may result in temporary or permanent paresthesia (numbness) of involved teeth, tissues, and associated structures. I accept these risks by consenting to the use of local anesthetics during my dental appointments. If I have a medical condition that necessitates antibiotic pre-medication before dental treatment, it is my responsibility to notify the dentist. I assume all responsibility for all medical consequences if the office is unaware of my need for pre-medication.

_____ **CHANGES IN TREATMENT PLAN:** I understand that any estimate given to me regarding my insurance coverage is an estimate and subject to change once reviewed by my insurance company. I understand that my insurance can change, deny, or recode any dental treatment according to my contract with them. I understand that during treatment it may become necessary to change, alter, or add to planned procedures because of conditions found while treating the teeth that were not discovered during the previous examination. I understand that any alterations to treatment may affect the total cost of my treatment and I accept responsibility for any and all expenses regardless of third party involvement.

_____ **REMOVAL OF TEETH:** Alternatives and consequences of tooth extractions will be explained to me. I understand that removing teeth does not always remove all infection and it may be necessary to have further treatment. I accept the risks involved should I have my teeth removed including pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue, and surrounding tissue that can last for an indefinite period of time. I understand that I may require additional treatment with a specialist if complications arise during or following treatment, the cost of which is my responsibility.

_____ **CROWNS, BRIDGES & VENEERS:** Should I receive a crown, bridge, or veneer, I understand that the dentist will make the best effort to match the color of my natural teeth. I understand that I am responsible for approval of the appearance prior to permanent placement. I further understand that I will be wearing a temporary crown/bridge/veneer, which may come off easily and that I must be careful to ensure that it remains in place until the permanent is placed. I realize the final opportunity to make changes to my new crown/bridge/veneer (shape, fit, or color) will be prior to cementation. It is also my responsibility to return for permanent cementation within 30 days from the tooth preparation. Excessive days may allow for tooth movement in which a new crown/bridge/veneer may have to be made. In this case, I understand that I will incur and take full responsibility for any additional charges. I understand that the edge of a crown/bridge/veneer is near the gumline, which is an area prone to irritation, infection, or decay. Proper brushing and flossing at home, a healthy diet, and regular professional cleanings are some preventative measures essential to helping control these problems. I understand that crowns/bridges/veneers may fracture and that they may come off, especially if chewing sticky or hard foods. I acknowledge that while a crown/bridge/veneer does not necessitate the need for a root canal, there may be a future need in which the dentist cannot forsee.

_____ **LAB COSTS:** I understand that Butt Joint Margin (D2999) is not covered by my insurance plan. I am aware that this is a cosmetic procedure done by the doctor and the lab. There may be other unspecified codes or name brand prosthetics that are not covered by my insurance plan. I understand that certain procedures require additional charges in order for my doctor to make my treatment available to me.

_____ **ENDODONTIC TREATMENT (ROOT CANALS):** Should I receive endodontic treatment, I realize that there is no guarantee that root canal treatment will "save" my tooth and that complications may occur from the treatment. Occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment, but may cause paresthesia (numbness). I understand that endodontic files and reamers are very fine instruments and stress vented in their manufacture can cause them to separate (break) during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. I understand that the tooth will require a crown after the root canal is completed, if not already crowned.

_____ **FILLINGS:** Should I have a filling, I understand that a more extensive filling than originally diagnosed nay be required due to additional decay or tooth defect discovered during the preparation of the filling. This may result in a fee increase for which I accept full financial responsibility. I accept that significant sensitivity is a common effect of a newly placed filling, which may necessitate further treatment in the form of a bite adjustment, crown, and/or root canal therapy in the future. I realize that extremely large fillings may require a crown to prevent further breakage.

_____ **TEETH WHITENING:** Should I have my teeth whitened, I understand that there is a range within which teeth can be lightened and that some teeth respond better to the whitening process than others. I understand that my teeth may become more sensitive after treatment and fluoride gel and/or time usually alleviate this. The whitening information sheet and application instructions will be explained to me. I understand that I will be given 3 syringes of bleach initially and will be responsible of payment in full for additional syringes.

CONSENT TO TREATMENT

I understand that dentistry is not an exact science; therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance will be made by anyone at Touch of Smiles Dental Care regarding the dental treatment that I authorize. I hereby authorize all doctors and staff members to proceed with and perform dental treatment as explained to me. I understand that my treatment plan is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of my treatment. I hereby authorize the performance of any additional care, procedure, or treatment not specified above that the dentist believes is necessary as a result of any unforeseen events or conditions. I understand that this is a general consent form and that I may be required to sign more specific consent forms based on the treatment that is proposed. I understand that my consent to dental treatment is also a consent to dental charges for which I am fully responsible. I certify that I have read and understand all of the above; I accept all risk in the hope of obtaining the desired beneficial results. I understand that if no treatment is done, my condition may worsen and continue to deterioriate.

PATIENT OR GUARDIAN SIGNATURE: _____

DATE: _____

HIPAA

The department of health and human services have established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment, or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at a future time you may request to refuse all or part of your PHI. You may not revoke actions which have already been taken which relied on this previously signed consent.

If you have any objections to this form, please ask to speak to the Office Manager. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

PATIENT NAME (PRINTED):_____

PATIENT OR GUARDIAN SIGNATURE: _____

DATE: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and costing them money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosures of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event, in any way, compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. **THANK YOU FOR BEING ONE OF OUR HIGHLY VALUED PATIENTS!**

TOUCH OF SMILES
DENTAL CARE, LLC

50 Scott Adam Road Suite 100 Cockeysville MD 21030 (410) 628–1818 fax (410) 628–1828

Authorization to Discuss Protected Health Information

Note: Completion of this form is optional.* ***ONLY COMPLETE THIS FORM IF YOU WISH FOR US TO DISCUSS WITH SOMEONE ELSE.* *To be valid, form must be filled out completely and include the information we are allowed to share.*

Patient Name: _____ DOB:_____

I give permission to: _____

Phone #: _____ Relationship to patient:_____

To verbally discuss the following dental/medical and billing information about me:
(Check all that apply)

- ☐ Scheduling/appointment information
- ☐ Medical/dental information; including my symptoms, diagnosis, medications & treatment plan. (This may also include information about behavioral health, chemical dependency, prenatal care, pregnancy, family planning & STD testing/treatment).
- ☐ Lab test results
- ☐ Billing and payment information
- ☐ Other

This authorization may be cancelled at any time in writing to this office, but will not affect any information already released. I understand that I should only sign if I want my provider to share my information with someone.

This authorization expires:
(Please check one)

- ☐ On this date: _____
- ☐ When cancelled in writing

Signature of Patient/Guardian: _____ **Date:**_____

Witness if Patient is Unable to Sign: _____ **Date:**_____

Reason Patient is Unable to Sign: _____

*If authorized representative, please attach copies of supporting legal documentation.