Port Jervis Smiles

Greetings and a warm welcome to our office!

Thank you for choosing us to take care of you. We would like you to be as open and honest with our staff as necessary. Communication is very important for everyone involved. We want you to feel comfortable and we will try to make your experience truly unique.

We have a personal, professional, and ethical responsibility to take care of your health to the best of our ability. We are asking you to make a pledge to your health as well. Please take time to read the following policy and procedures. Your signature is required at bottom to further show your commitment.

1. **Diagnosis:** It is of utmost importance that you completely understand your treatment diagnosis. It is okay if you need more information or visuals. Please be aware that although our office tends to be conservative with treatment, the Doctor or Hygienist cannot ethically withhold a treatment plan due to your personal situation. This is not a "Watch and Wait" office. All treatment planning is in *your* best dental interest, not *ours*.
2. **Radiographs:** Radiographs are crucial to properly diagnose treatment. The doctor cannot accurately diagnose problems or develop a treatment plan without the use of clear and up to date radiographs.
3. **Timeliness:** In this busy society, we know that your time is important. We expect that you will be on time for all your appointments as we make every effort to stay on time and get you in and out in the time you were promised. We request that you provide your mobile number to help us contact you during any unforeseen circumstances such as office closure due to snow etc.
4. **Pre-scheduling/Cancellations:** We pre-schedule all our appointments and this time is especially reserved for you. A 72 hour notice to change any appointment is expected. This allows for everyone to get the proper amount of time with the doctor or hygienist as we do not double book either one. This will give an opportunity to other patients who will be happy to take that appointment. Any appointments canceled or rescheduled without a 48 hours advance notice are subject to a $50 broken appointment fee. For Monday appointments, please call by the prior Thursday.
5. **Insurance:** Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. We will provide you with a "guesstimate" of benefits. However, you are financially responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We are not responsible for what your insurance will or will not cover. Please note that any insurance balance not received after 60 days will also become your responsibility.
6. **Zero Balance Policy:** Our office focuses on patient care as job #1. To avoid this focus to deviate from care to chasing money, we have instituted a zero balance policy. Any and all payments

must be made at the time when treatment is started. We are happy to offer payment options to you to be able to afford major treatment and pay at a comfortable pace. All patients are expected to comply with their financial agreement.

I have read and understood the Port Jervis Smiles "Policy & Practice".

Patient Signature: _____

Patient Name: _____

Cell/mobile #: _____

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

DATE _____

(PLEASE PRINT)

NAME _____ (FIRST / MI / LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

SIGNATURE

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____ SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER _____
☐	☐	SULFA DRUGS	☐	☐	IODINE			_____

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER _____
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			

COMMENTS

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

Port Jervis Smiles

Most dental offices treat just the tooth. We treat the whole patient!

We strive to grow our practice with honesty, hard work and structure

At Port Jervis Smiles,

- We are able to focus on you and your family's dental health in relationship to your overall health. We believe there is a direct mouth-body connection and we will address this issue as we help care and update you.
- We strive to make you comfortable as a part of our dental family.
- We hope that you will feel better about yourself, your appearance and gain more self-confidence after spending time with us.
- We strive to make each visit a positive and delightful experience where you feel valued, cared for and appreciated.
- We desire to respect you and your time demands.
- We strive towards continual improvement in our care through daily huddle meetings, monthly staff and training meetings, technological advancements, providing patient education, and continuing education for all staff members.
- We strive to provide the highest level of safety and infection control for your personal protection.

Our goal is to help you preserve your natural teeth through optimum dental care. We hope to "wow" you with our level of care, empathy, understanding and patient care.

If you have ANY questions or comments about our office, staff, procedures or need any other dental information **PLEASE** feel free to e-mail us at portjervissmile@gmail.com

MISSED APPOINTMENT POLICY

We respect the importance of your time and work very hard to schedule appointments which accommodate the busy schedule needs of all of our patients. In return, we ask patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as our practice. If emergency circumstances prevent you from keeping an appointment we certainly understand, all we ask is that you call us immediately so we can try to accommodate another patient.

Ultimately as with any appointment, it is your responsibility to keep track of your appointments. We ask you to provide us with a minimum of forty-eight business hours notice. Failure to do so may result in a cancellation/missed appointment fee of $50.00

We also make reminder calls to our patients two business days prior to all appointments. This effort shows our commitment to all of our patients and the importance of their health.

If you have any questions please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation in this matter.

I acknowledge that I have read this statement and agree to the contents.

Signature:_____

PATIENT HIPAA AWARENESS

With my permission, Port Jervis Smiles may use and disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). Please refer to Port Jervis Smiles Notice of Privacy Practices for a more complete description of such use and disclosers.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Port Jervis Smiles reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Port Jervis Smiles may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results.

With my permission, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements may be mailed to my home or other designated location. I have the right to request that Port Jervis Smiles restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am allowing Port Jervis Smiles to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosers in reliance upon my prior consent.

I acknowledge that I have read this statement and agree to the contents.

Signature of patient, or guardian (responsible party)

Signature:_____ **Date:**_____