swan smiles & orthodontics

nephi smiles & orthodontics

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Patient Information

PERSONAL

Name (First & Last) _____ MI _____ Preferred: _____

Birth Date _____SSN# _____ Gender: ☐ M ☐F Married: ☐Y ☐N

Wireless Ph# _____ Home Ph# _____ Work Ph# _____

Email: _____

Whom may we thank for referring you ? _____

RESPONSIBLE PARTY & ADDRESS

Check box if same for entire family ☐

Responsible Party: _____ Responsible Party's Birthday: _____

Address _____

Address 2 _____

City _____ State _____ Zip Code _____

INSURANCE POLICY 1

Your relationship to Subscriber ☐ Self ☐ Spouse ☐Child

Subscriber Name _____Subscriber DOB:_____Subscriber ID # _____

Insurance Company _____Phone _____

Employer _____ Group Name _____ Group # _____

Please Present insurance card to receptionist

INSURANCE POLICY 2

Your relationship to Subscriber ☐ Self ☐ Spouse ☐Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____Phone _____

Employer _____ Group Name _____ Group # _____

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Medical History for Patient

Patient Full Name: _____ Birth Date: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone # _____

Relationship: _____

List of Medications & Strength that you are now taking:

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following? *Check all that apply*

☐ Anesthetic ☐ Aspirin ☐ Codeine ☐ Ibuprofen ☐ Iodine

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Metals ☐ Other: _____

Do you have any of the following medical conditions? *Check all that apply*

☐ Asthma ☐ Bleeding Problems ☐ Cancer ☐ Diabetes

☐ Heart Murmur ☐ Heart Trouble ☐ JointReplacement ☐ High Blood Pressure

☐ Kidney Disease ☐ Liver Disease ☐ Pregnancy ☐ Psychiatric Treatment

☐ Sinus Trouble ☐ Stroke ☐ Ulcers ☐ Other: _____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections?_____

Reason for today's visit _____ Are you in pain? _____

Other Concerns not listed: _____

_____

Signature of Patient, Parent or Guardian: _____ **Date:** _____

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Financial Agreement

Financial:

_____ (initial) I agree to pay the fees charged for dental services provided by the dentist or his/her assignee at the time the services are rendered. **This office provides a discount for all cash payments and charges convenience fees for electronic payments.** A service charge of 1.5 % per month (18% annually) will be charged on any unpaid balance exceeding sixty (60) days from the date of service, unless other financial agreements have been made. If a balance is carried on my account for more than ninety (90) days, it will be turned over to a collection agency. I agree to pay the remaining balance plus reasonable attorney fees, court costs and a 40% collection fee if payment in full for charges incurred is not made. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary. This agreement supersedes all prior agreements signed including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care is null and void.

Insurance:

_____ (initial) As a courtesy, we accept assignment of benefits for primary and secondary insurance. It is your responsibility to provide our office with complete and accurate insurance or billing information at the time of service. **Our office cannot guarantee the amount that an insurance company will pay**. Your insurance is a contract between you and the insurance company and we are not a party to this contract. Disputes with insurance companies are the responsibility of the insured. We have no control over the terms of your contract, the methods of reimbursement, or the determination of benefits. You agree to be responsible for payment of all services rendered to you or your family. You are responsible to pay your estimated portion when services are rendered. **Any amount not covered by insurance or any difference in the estimated portion is the parent or guardian's responsibility**.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any other entities that require such information to be submitted.

Appointments:

_____ (initial) I understand that appointments are an agreement and I am responsible to keep all scheduled appointments. **If for any reason I am unable to keep an appointment I need to give the office at least 24 - 48 business hours' notice. Any broken appointments will incur a $25 fee**. Sedation appointments that are missed will incur up to a $100 fee. I also understand that if I am late to an appointment it may have to be rescheduled for a different day. I am aware that if I do not come to an appointment I will be charged a broken appointment fee. **The third missed appointment, within one year, will lead to a letter of dismissal from the practice.** I understand and agree to pay the rescheduling/broken appointment fee if I miss an appointment, if I am excessively late or if I do not give the proper amount of notice.

We understand that there are circumstances that may prevent you from keeping your appointment, we ask that you kindly give us a 24-48 hour notice.

I have read and understand the above policies and agree to abide as outlined.

Name (Please Print): _____

Signature of Patient, Parent or Guardian: _____ Date: _____

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Privacy Policies

Contact:
I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Swan Smiles. I understand and agree that such calls may be initiated by Swan/Nephi Smiles or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages - some or all of which may result in data charges. I also consent to receiving emails at any e-mail address provided by me or anyone associated with me or acting on my behalf. I consent to each of these contact methods being used to contact/inform me on appointment, financial, and other miscellaneous matters.

Consent to Proceed

I authorize Swan/Nephi Smiles and/or such associates as he may designate to perform those procedures as may be necessary or advisable to maintain my dental health. Including but not limited to nitrous oxide, general anesthesia and all those related to restorative, palliative, therapeutic, or surgical treatment. I understand that the administration of local anesthetic may cause an outward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation and temporary or rarely permanent numbness and muscle soreness. 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 not be achieved for my benefit. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.
*If the above named person is a minor or other ward to which I am responsible, the preceding is also understood.

Patient Photo Consent:
I hereby authorize Swan Smiles & Orthodontics/Nephi Smiles & Orthodontics or any of their assignees to take photographs, slides, and videos. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook, instagram, etc).
I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my name or other identifying information will not be used. I do not expect compensation, financial or otherwise, for the use of these records.
Please initial :

_____ I do not mind if my records are used in any of the above stated situations.

_____ I do not wish to have my face shown

_____ I do not wish to have my photo used at all

I have read and understand the above policies and agree to abide as outlined.

Name (please print): _____

Signature of Patient, Parent or Guardian _____ Date_____

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HIPAA Compliance Patient Consent Form

SECTION I: PERSON AUTHORIZING HIPAA CONSENT

PATIENT/PARENT/LEGAL GUARDIAN NAME: _____

RELATIONSHIP TO PATIENT(S): _____

SECTION II: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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

Notice of Privacy Practices: 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, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

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 any 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. 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 continue treating you if you revoke this Consent.

SECTION III: AUTHORIZATION

I authorize Swan Smiles & Orthodontics to disclose or discuss the following information:

- **Appointments** Yes / No
- **Accounts/Balances** Yes / No
- **Insurance** Yes / No
- **Treatment** Yes / No

If **YES,** please list the persons authorized to receive your Protected Healthcare Information:

Full Name _____ **Relationship** _____

Full Name _____ **Relationship** _____

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE: _____ **DATE**: _____