# Smiles on Maple

# 3070 N Maple Ave.

# Zanesville, OH 43701

## Appointment & Financial Policy

Thank you for choosing our office for your dental care. We appreciate you allowing us to provide you with the best quality of care. We attempt to provide you with an overall hassle-free positive experience from start to finish. The following represents our patient and financial policies so that you are aware of what we need to better serve you.

We participate in many insurance plans and bill your insurance as a courtesy. We ask that if you are insured that you have your insurance care and photo id with you at the time of your appointment. If you are not insured payment will be due when services rendered.

Co-payments, deductibles, and co-insurance must be paid at the time of service. If you are unable to pay your out-of-pocket portion for services, we will have to reschedule your appointment. If you need to make financial arrangements, we have payment options and financing available to help make your dental treatment affordable. See our front office team for more information.

Please understand that some services will not be covered by your plan. They may consider some services unnecessary or unreasonable. Insurance companies at times can be difficult but we do our best to alert you prior to your appointment of any possible undercovered expenses that may be your responsibility.

Appointments in our office are reserved times we set aside for you. No shows and last minute cancellations are not only a frustration to our doctor but to our staff who coordinate and prepare treatment rooms for your care. Should you need to reschedule we do require a 24 hour notice. We value your time and ask that you value your appointment time as well. Broken appointments will lead to dismissal from our practice.

My signature below acknowledge that I have read and understand the Appointment & Financial Policy

Signature _____ Date _____

# HIPPA Compliance Patient Consent Form

Our notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patients' rights section describing your right under the law. You ascertain that by your signature you have reviewed our notice before signing the consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent.

**Please circle:**

**May we phone, email, or send text to you to confirm appointments: YES or NO**

**May we leave a message on your voicemail with health information: YES or NO**

**May discuss your medical condition with any family members: YES or NO**

**If yes, please name members allowed:**

_____

_____

This consent was signed by: _____

(PRINT NAME)

Signature: _____

Date: _____

# Health History

## Confidential

Patient Name: _____ Date: _____

Reason for today's visit

_____

**NEW PATIENT:** Former dentist/Approx. date of last exam _____

CIRCLE If you have had problems with any of the following:

| | | |
|---|---|---|
| Bad Breath | Sensitivity to Hot/Cold/Sweets | Food collecting between teeth |
| Bleeding Gums | Jaw Pain/Clicking or popping | Grinding Teeth |
| Sensitivity when biting | Sores in your mouth | Loose teeth or broken fillings |

How often do you floss? _____

How often do you brush? _____

Do you feel that an attempt to save your teeth is a waste of time? Yes / No

## Medical History

Physicians Name & Date last visit:

_____

Have you had any serious illnesses or operations? Yes / No If yes, describe:

_____

Has there been any change in your general health in the last year: Yes / No

**Allergies:** YES NO

Please List:

_____

_____

**(WOMAN) ARE YOU PREGNANT?** Yes / No Taking birth control: Yes / No Breast Feeding: Yes / No

Circle if you have or had any of the following:

| | | | |
|---|---|---|---|
| Anxiety/Depression | Cancer | Heart Problems | Skeletal Bone Loss |
| ADHD/ADD | Chemotherapy | Hepatitis | Smoke/Vape/Rub Snuff |
| Abnormal Bleeding | Cortisone Treatments | High/Low Blood Pressure | Stroke |
| Arthritis/Rheumatism | Cough up Blood | HIV/AIDS | Thyroid Problems |
| Artificial Heart Valves | Diabetes | Kidney Disease | Tonsillitis |
| Artificial Joints | Drug Addiction | Liver Disease | Tuberculosis |
| Asthma | Epilepsy | Pacemaker | |
| Back Problems | Fainting | Respiratory Disease | |
| Blood Disease | Headaches | Shortness of Breath | |

Please list Medications:

_____

_____

## Welcome to Smiles on Maple

## Patient Information

Patients Name: _____

Address_____ City/Zip _____

Cell#: _____ Home#:_____

Email address:_____

Sec: Male or Female Birthdate: _____/_____/_____

Circle: Single Married Widowed Divorced - Name of Spouse: _____

If Minor - Guardian/Parents Name: _____

Address if different than patient: _____

Any other members of household (same address) patients of Smile or Maple? If yes, please list:

_____

## BILLING INFORMATION

Responsible Party Name: _____

Relationship to Patient: _____

Billing Address City/Zip:_____

Insured Policyholder: _____ SS#:_____

Employers Name: _____ Phone #: _____

Insurance Company Name: _____ ID/Group #: _____

## IN CASE OF EMERGENCY-CONTACT

Name: _____ Contact #:_____

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE SMILES ON MAPLE NOTICE OF PRIVACY PRACTICES. The information on this page will be confidential.

Patient or Responsible Party:

Sign X: _____ Date: _____