WELCOME

ABOUT YOUR CHILD

Today's Date _____ ☐ Male ☐ Female

Child's Name: _____ Nickname: _____
Last First Mi

Birthdate: _____ Age: _____ Social Security #: _____

Home Address: _____
Street Apt # City State Zip

Home Phone #: (___) _____ Who and when are best for making appointments? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

PARENT'S INFORMATION

MOTHER: Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single

Name: _____ Social Security #: _____ Birthdate: _____

Address: _____ Home phone #: _____
Street/PO Box City State Zip

Employer: _____ Work phone #: _____

FATHER: Parent(s) Email Address: _____

Name: _____ Social Security #: _____ Birthdate: _____

Address: _____ Home phone #: _____
Street/PO Box City State Zip

Employer: _____ Work phone #: _____

PERSON RESPONSIBLE

Name: _____ **Relation:** _____ **Home Phone #:** (___) _____ **Work Phone #:** (___) _____

Employer: _____ **Work Phone #:** (___) _____ **Ext.** _____

Billing Address: _____
Street/PO Box Apt # City State Zip

INSURANCE INFORMATION

Primary Insurance

Insurance Company Name: _____ Phone #: (___) _____ Group # (Plan or Policy #): _____

Insurance Company Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance

Insurance Company Name: _____ **Phone #:** (___) _____ **Group # (Plan or Policy #):** _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ **Insured's Social Security #:** _____ **Insured's Birthdate:** ___/___/___ **Relation:** _____

Insured's Employer: _____ **Employer's Address:** _____
Street/PO Box City State Zip

AUTHORIZATION

I certify that my child is covered by _____ Insurance Company and I assign directly to Dr. Douglas F. Smith all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature Date

The parent or guardian who accompanies the child is responsible for payment at time of service.

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INFORMED CONSENT

I hereby authorize Dr. Douglas F. Smith, or any associate, or assistant to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a diagnosis of my dental needs. I hereby authorize Dr. Smith and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward 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 understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.

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 or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature Date

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services finished are charged directly to the patient and that he or she is personally responsible for payment of dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

If you do not pay the entire balance of your account within 30 days of receipt of a monthly statement, a FINANCE CHARGE/REPEAT BILLING CHARGE may be added to your balance. The FINANCE CHARGE/REPEAT BILLING CHARGE will be a periodic rate of 1.5% per month (or a $5.00 minimum REPEAT BILLING CHARGE on a balance under $200.00) which is an ANNUAL PERCENTAGE RATE of 18%. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collections fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if a suit instituted hereunder to collect monies owed by me. 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.

I grant permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form.
This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge hat any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.
I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted.
Due to the busy nature of our office, we require that there be a 24-hour notice of cancellation. Failure to do so may result in a $20.00 service charge. Three (3) consecutive missed appointments without notice will result in the patient's name being dropped from our records.

I certify that I have read and answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, parent or guardian **Date** **Relationship to Patient**

MEDICAL HISTORY

Child's Physician: _____ Phone #: (___) _____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child under the care of a physician? ☐ Yes ☐ No Please explain: _____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are immunizations current?** ☐ Yes ☐ No

Is your child allergic to any of the following?

Y N	**Aspirin**	Y N	**Dental Anesthetics**	Y N	**Latex**	Y N	**Sulfa Drugs**
Y N	**Barbiturates**	Y N	**Erythromycin**	Y N	**Penicillan**	Y N	**Tetracycline**
Y N	**Codeine**	Y N	**Jewelry**	Y N	**Sedatives**	Y N	**Other**

Please list additional drugs that cause allergic reactions: _____

Is your child taking any of the following?

Acetaminophen	☐ Yes ☐ No	Blood Thinners	☐ Yes ☐ No	Insulin/Diabetes Drugs	☐ Yes ☐ No	Tranquilizers	☐ Yes ☐ No
Antibiotics	☐ Yes ☐ No	Blood Pressure Medication	☐ Yes ☐ No	Nitroglycerin	☐ Yes ☐ No		
Antihistamines	☐ Yes ☐ No	Cold Remedies	☐ Yes ☐ No	Steroids/Cortisone	☐ Yes ☐ No		
Aspirin	☐ Yes ☐ No	Digitalis/Heart Medication	☐ Yes ☐ No	Thyroid Medicine	☐ Yes ☐ No		

Is he/she taking any prescription/over-the-counter drugs not listed above ☐ Yes ☐ No If yes, please list each one: _____

Has your child experienced/experiencing the following?

Y N	Abnormal Bleeding	Y N	Diabetes	Y N	Low Blood Pressure
Y N	AIDS/HIV +	Y N	Epilepsy	Y N	Lupus
Y N	Anemia	Y N	Handicaps/Disabilities	Y N	Measles
Y N	Allergies	Y N	Hearing Impairment	Y N	Mitral Valve Prolapse
Y N	Any Hospital Stays	Y N	Heart Murmur	Y N	Mononucleosis
Y N	Asthma	Y N	Hemophilia	Y N	Rheumatic Fever
Y N	Blood Transfusions	Y N	Hepatitis	Y N	Scarlet Fever
Y N	Cancer	Y N	High Blood Pressure	Y N	Sickle Cell Anemia
Y N	Chicken Pox	Y N	Hives	Y N	Skin Rash
Y N	Congenital Heart Def.	Y N	Kidney Problems	Y N	Tonsilitis
Y N	Convulsions	Y N	Liver Problems	Y N	Tuberculosis (TB)

Please discuss any serious medical problems the child experiences/ed: _____

DENTAL HISTORY

Is the child currently in pain? ☐ Yes ☐ No **What is the primary reason for today's visit?** _____

Has the child ever had any pain/tenderness in his/her jaw (TMJ/TMD)? ☐ **Yes** ☐ **No**

Has the child experienced problems with previous dental work? ☐ Yes ☐ No

Is the child's water flouridated? ☐ Yes ☐ No Is the child taking fluoridated supplements? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No Floss his/her teeth daily? ☐ Yes ☐ No

Does your child's gums ever bleed? ☐ Yes ☐ No Your child's current dental health is: ☐ Good ☐ Fair ☐ Poor

Does/did the child have any of the following habits?

Y N	Lip Sucking/Biting	Y N	Clenching/Grinding Teeth	Y N	Tongue/Cheek Biting
Y N	Nail Biting	Y N	Used Pacifier	Y N	Speech Problems
Y N	Chewing on Objects	Y N	Nursing Bottle Habits	Y N	Tongue Thrust
Y N	Mouth Breather	Y N	Thumb/Finger Sucking	Y N	Breast Fed

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient, parent, or guardian Date Relationship to Patient

DOUGLAS F. SMITH, INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print 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:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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 your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, 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 changes 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 a significant change 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 practitioner and provider performance, conducting training programs, accreditation, certification, 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.

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 payment for your 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 or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $ 10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: 435-752-4882 Fax: 435-752-4882

E-mail: _____

Address: 160 EAST 200 NORTH, SUITE J, LOGAN, UT 84321