MODERN SMILES FAMILY DENTISTRY

4022 E GREEWAY RD STE 12
Phoenix AZ 85032
602.457.4788

New Patient Profile

Patient Name:

Last	First	MI	Preferred Name
________________________________	___________________________________	_____	____________________________

Title: Mr/Ms/Mrs/etc __________________________________

Gender: Male/Female ______________

Family Status: Married/Single/Child/Other _______________

DOB : ______/______/_______ SSN: _______________________

Email Address: ____ Best time to call: _______________

Home Phone: (_______) ____________________________________ Cell/Other: (_______)____

Address: ____ City: ____________________ State______ Zip_________________

Please check all that apply:

- ☐ You may contact me at my home telephone number
- ☐ You may contact me on my mobile telephone number
- ☐ You may send me an e-mail
- ☐ You may contact me via text messaging

Whom may we thank you for referring you to our practice?: ____

In the event of an emergency, who should we contact? Please list name and phone number below:

Emegency contact (ICE):____

Employment Information

Employer Name: ____ Phone: _______________________________

Employer Address: ____

City: ____ State______ Zip_________________

Name of Responsible Party: _____________________________________ DOB: ____/____/_____ Relation to you: ______________________

Address: ____ City: ____________________ State______ Zip_________________

Email Address: ____ Employer: _______________

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Home Phone: (_______) ___________________________________ Cell/Other: (_______)_______________________________________

Insurance Information

At Modern Smiles Family Dentistry, we realize how important insurance benefits are. We ask that *you* carefully review your policy and/or contact your insurance carrier, so that *you* are aware of benefits, frequencies, limitations, and/or restrictions. Please be informed that YOUR dental insurance is a contract between YOU and YOUR insurance company. <u>Our role is to simply assist you with filing your claims</u>. While we will obtain a summary of benefits from your insurance *it is your responsibility* to know the frequencies, limitations and/or restrictions of your plan. We ask of you to provide us with any changes to your coverage. If any dental services have been provided to you by any other provider within the existing benefit year, please advise us. Any portion of treatment that your dental insurance does not pay will be your financial responsibility.

Primary Dental Insurance Company: ________________________ Insurance Co. Telephone Number: ___________________________

Primary Subscriber Name: ________________________________ Relationship to Subscriber: _______________________________

DOB: ____/____/_____ SSN: _____________________________ Insurance Claim Address: __________________________________

Subscriber ID #: _______________ Group Number: ___________ ____

Do you have secondary dental insurance? □ Yes □ No

Dental Information

What is the reason for your visit today?

____

____

Date of most recent dental exam and xrays:

____

Previous Dentist and phone number:

____

Is there anything about the appearance of your smile that you would like to change?

____

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment

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- ☐ You experience dry mouth
- ☐ Food gets trapped between any teeth
- ☐ You have difficulty chewing
- ☐ You wear or have worn a bite appliance
- ☐ Diagnosed and/or treated for gum disease
- ☐ Experienced gum recession
- ☐ TMJ/TMD discomfort/pain
- ☐ Any teeth sensitive to hot/cold/biting/sweets
- ☐ Have you ever bleached/whitened your teeth
- ☐ You clench or grind your teeth
- ☐ Gums bleed when brushing/flossing
- ☐ Noticed an unpleasant taste or odor in mouth
- ☐ Teeth become loose on their own (without injury)
- ☐ You snore or wake up frequently during the night

If any of the above checked boxes need further explanation, please describe:

____

____

Medical History

What is your estimate of your general health? (circle one)

Excellent Good Fair Poor

Please check any allergies or adverse reactions you may have to the following:

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Hay Fever
- ☐ Latex
- ☐ Penicillins
- ☐ Sulfa
- ☐ Other:

Please list any medications you are currently taking:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Do you need to be pre-medicated with antibiotics for any heart or other medical conditions prior to dental treatment? □ Yes □ No

If yes, please list: ____

Are you currently under the active care of a physician or do you have any present health issues? □ Yes □ No

Name of your physician and your most recent physical exam

____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

____

Do you smoke? How much/how often? ________________________

Do you drink alcohol? How much/how often? ___________________

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Females only:

Are you pregnant or nursing? □ Yes □ No

Are you taking contraceptives? □ Yes □ No

Nursing □ Yes □ No

Using Hormone Replacement Therapy □ Yes □ No

Medical History Continued

Please indicate which of the following conditions you have or have had in the past.

Check or mark for "Yes" , leaving blank will indicate a "No" response

___________ Allergies

___________ Anemia

___________ Arthritis

___________ Artificial joints/valves

___________ Asthma

___________ Autonomic Dysfx

___________ Blood thinners

___________ Blood Transfusion

___________ Cancer/Chemotherapy

___________ Celiac Disease

___________ Cold Sores

___________ Colitis

___________ Coronary Artery Dis

___________ Crohn's Disease

___________ Deviated Septum

___________ Diabetes

___________ Difficulty Breathing

___________ Emphysema

___________ Fainting Spells

___________ Fibromyalgia

___________ Glaucoma

___________ Hay Fever

___________ Heart Attack

___________ Heart Murmur

___________ Heart Surgery

___________ Hemophilia

___________ Hepatitis

___________ HIV+/AIDS

___________ High Blood Pressure

___________ Herpes/Fever Blisters

___________ Hospitalization (w/in 5 yrs)

___________ Jaw Pain/TMJ

___________ Kidney Problems

___________ Liver Disease

___________ Low Back/Hips/Leg Pain

___________ Low Blood Pressure

___________ Lupus

___________ Mitral Valve Prolapse

___________ Neck/Shoulder/Arm Pain

___________ Nervous Sys Disorders

___________ Osteoporosis

___________ Pacemaker

___________ Psychiatric Care

___________ Rashes

___________ Rheumatic Fever

___________ Rheumatism

___________ Seizures

___________ Shingles

___________ Sinus Problems

___________ Sickle Cell Disease

___________ Spasms/Cramps

___________ Stomach Problems

___________ Stroke

___________ Thyroid Disorder

___________ Trigeminal Neuralgia

___________ Tuberculosis (TB)

___________ Ulcers

___________ Venereal Disease

___________ Other

Please explain/clarify any conditions/alerts from above:

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____

____

Patient Signature _______________________________ Date__________________

Doctor Signature _______________________________ Date__________________

Consent for Services

I understand and authorize Dr. Frederick Lin and partners to take all diagnostic materials necessary to make a final diagnosis of dental treatment. Diagnostic materials may include intra-oral pictures, digital radiographs, diagnostic models, photographs and slides. This material may be used for lectures, articles and/or publications. I authorize Dr. Frederick Lin and partners to perform and/or administer any and all forms of treatment, medication and anesthesia that may be necessary. I hereby authorize Dr. Frederick Lin and partners to charge any un-paid services to my credit card. All emergency dental services, and any dental services performed without previous financial arrangements, must be paid for in full at time services performed.

Any necessary orthodontic, root canal, oral surgery, implant placement, apicoectomy, or periodontal treatment will be referred out to a specialist (outside this office) for an additional fee unrelated to this office.

I understand the fee estimate listed for this dental care can only be extended for a period of **six** months from the date of the patient examination.

I understand that no medical or dental procedure is totally predictable. I understand that because of known or unforeseen factors, further treatment beyond those described to me might be necessary at an additional cost. Due to subjectivity of aesthetic outcomes, I understand that should I wish to redo any procedure for aesthetic reasons, I will be responsible for fees incurred for the doctors' time, lab costs, and overhead. Such procedures will be done at the doctors' discretion pertaining to the best interests of my oral health.

If I have dental insurance, Dr. Frederick Lin's staff will gladly process your forms as a courtesy to his patients. I agree to pay my **estimated** portion of dental services that are rendered. I understand that Dr. Frederick Lin's contract for payment is with me and not my insurance carrier. I will provide Dr. Frederick Lin with updated and accurate insurance coverage, and will promptly notify Doctor/staff of any changes. After 45 days from the date of service, any non-payment from an insurance company I will assume financial responsibility for.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his associate, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed. 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 suit be instituted hereunder.

I understand a late cancellation of under 24-hours, a fee of $50 may be charged at the office's discretion.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_______________________________ _______________________

Patient/Guardian Signature Date

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HIPAA Acknowledgement

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of our policies have been part of our practice for years. This form is a 'friendly' version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, or by any means convenient for the practice and /or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The Practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services without written consent.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By signing below, I understand the above information and agree with its contents.

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____ ____________________

Patient/Guardian Signature Date