Smile Avenue Family Dentistry
9212 Fry Rd #120, Cypress, TX 77433
(832) 648 1756
www.smileavenuefamilydentistry.com/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature: Date:

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PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

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1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

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FINANCIAL POLICY

Payment

We require that payment be rendered on the day of service. We will estimate the amount of copay required from the information that your insurance company provides to us. Please keep in mind, though we make every effort that these estimates are accurate, we cannot possibly be correct 100% of the time due to the many clauses and stipulations that are inherent in individual policies. In other words, every policy is unique, and an estimate is not a contract.

Underpayment by insurance
In the case that your insurance company pays less than what we estimate, you will be responsible for the balance. You will be emailed a statement and if no payment is rendered within 30 days, your account will be forwarded on to a collections company.
Missed or short notice cancellation policy
We require 24 business hours notice to cancel or change your appointment. If adequate time is not allowed, we will charge your account a $75 cancellation/late notice fee.

Easy Checkout Policy
Our system has the capability to store tokens for credit card usage through our merchant service processor. What this means, is that we can use the last credit card you used here at the office to take care of your bill or the bill of your family if you request it. This is PCI compliant with all credit card laws and completely safe as the numbers are not stored by our system, but our system can call our credit card company to retrieve the information using what is called tokens. This way, we do not need to swipe your credit card each time you need to pay us.

Small Balance Policy
In the instance that there is a small (less than 100 dollars) left on your account (i.e. in the case of insurance underpayment); you will receive a statement with a reminder that the balance reflected will be posted to the last used card on file. If you should choose to use an alternate form of payment, contact us within 30 days of the statement date.

Finance Charges
Accounts not paid in full within 10 days of the date on the invoice are subject to a 9% APR finance charge.
By signing below, you confirm that you have read our financial policy and consent to us drafting the last credit card used at the practice to take care of unpaid balances of less than 100 dollars. We will contact you before ever charging anything to your credit card in case you would like to make another arrangement.

Patient's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Smile Avenue Family Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Smile Avenue Family Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Smile Avenue Family Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Smile Avenue Family Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Smile Avenue Family Dentistry.

Patient's signature: Date:

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NEW PATIENT FORM (MINOR)

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
Referral source:		School:	
Referred by:		Special needs:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Parent/Guardian (Primary Contact)

Full Name:	
Relation:	
DOB:	
Mobile phone:	
Email:	
Has legal custody:	
Employer:	

Parent/Guardian (Secondary)

Full Name:	
NOT PROVIDED	

Parent/Guardian (Primary Contact)

Home phone number	

Patient's signature: Date:

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CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Smile Avenue Family Dentistry and their staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my childs dental problem. I will allow photographs to be taken of my child or childs teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. We will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Smile Avenue Family Dentistry of any changes in my childs medical status.

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Patient's signature: Date:

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HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

General Health Information

Are you currently under the care of a physician?	
Physician phone number	
What is your preferred pharmacy? (Name, Address, Phone #)	
Date of last physical exam	
Are you presently being treated for any injury or illness?	
Have you ever been hospitalized for an injury or illness?	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	
Do you use alcohol?	
Do you use or have you ever used tobacco?	
Have you ever had an allergic reaction?	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for	
Do you have a history or are currently being treated for any Digestive conditions?	
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	
Do you have a history or are currently being treated for any Neurological conditions?	
Do you have a history or are currently being treated for any Lung or Breathing conditions?	
Do you have a history or are currently being treated for any Autoimmune conditions?	
Head or neck injuries?	
High cholesterol?	
History of cancer?	
Tumor or abnormal growth?	
Radiation therapy?	
Chemotherapy?	
HIV / AIDS?	
Osteoporosis/osteopenia?	
Type I or Type II diabetes?	
Anemia?	
Kidney disease?	

Liver disease?	
Thyroid disease?	
Tuberculosis, measles, chicken pox?	
Any other medical condition we should know of?	

Medications

Please check all medications you are currently taking	
Are you taking any pain medications?	
Are you taking any Antidepresants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Are you currently taking any other medications or dietary supplements?	

Patient's signature: Date:

Doctor's signature: Date:

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HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

Healthcare Provider

Child's Physician/Pediatrician	
Physician/Pediatrician phone number	
Pediatrician's Address	
Preferred Pharmacy	
Date of last physical exam	

General Health Information

Does your child have any allergies?	
Is your child currently taking any medications?	
Has your child ever been hospitalized, had general anesthesia, or emergency room visits?	

Medical Conditions

Is your child past due for any vaccinations?	
Have you ever been told that your child needs to take antibiotics before dental treatment?	
Were there any difficulties at birth?	
Is your child currently being treated for, or has a history of any medical conditions?	

Patient's signature: Date:

Doctor's signature: Date:

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DENTAL HISTORY
| DOB:

General Information

Who was your previous Dentist and how long were you a patient there?	
Date of your last dental exam	
Date of your last cleaning	
Do you have any immediate concerns you'd like us to address?	

Office Relationship

What do you value most in your dental visits?	
Is there anything you prefer during your visits to make you more comfortable during your time with us?	
On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?	

Personal History

Please answer the following questions	
Are you concerned about the appearance of your teeth?	
Are you interested in improving your smile?	
Have you had any cavities within the past 2 years?	
Are any teeth currently sensitive to biting, sweets, hot, or cold?	
Do you avoid or have difficulty chewing or biting heavily any hard foods?	
Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth?	
Do you clench your teeth in the daytime?	
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?	
Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?	
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?	
Have you ever noticed a consistently unpleasant taste or odor in your mouth?	

Dental Structural History

Please answer the following questions	
Do your gums bleed when brushing or flossing?	
Is brushing or flossing typically painful?	
Have you ever experienced or been told you have gum recession?	
Have you ever been treated for or been told you have gum disease?	
Have you had any teeth removed for braces or otherwise?	
Do you know of any missing teeth or teeth that have never developed?	
Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?"	

Are your teeth becoming more crowded, overlapped, or "crooked?"	
Are your teeth developing spaces?	
Do you frequently get food caught between any teeth?	
Have you noticed your teeth becoming shorter, thinner, or flatter over the years?	
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)	
Is it often difficult to open wide?	
Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together?	

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Doctor's signature: Date:

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DENTAL HISTORY
| DOB:

General Information

Who was your child's previous Dentist?	
Date of your child's last dental exam	
Date of your child's last cleaning	
What is the reason for your child's dental visit?	

Personal History

Has your child experienced any unfavorable reaction from previous dental care?	
Does your child suck a finger, thumb, or pacifier?	
Does your child have pain with chewing, yawning, or wide opening?	
Does your child go to bed with a bottle or sippy cup?	
Does your child snack frequently?	
Has your child had local anesthetic?	
Has your child been sedated for dental treatment?	
Have your child's teeth ever been injured?	
Does your child use fluoride toothpaste?	

Dental Problems

Please check if your child is having problems with any of the following	
Cavities	
Trauma	
Orthodontics	
Toothache	
Gum Infections	
Jaw Sounds	
Sensitive Teeth	
Color of Teeth	
Grinding of Teeth	
Mouth Breathing	
Other	

Patient's signature: Date:

Doctor's signature: Date:

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DENTAL INSURANCE INFORMATION

| DOB:

Created at: **01/05/2023 4:45:42 AM**

Primary Insurance Information

Do you have a dental insurance?	
Would you like to upload insurance card photo?	
Patient’s relationship to the Insurance Holder	
Insurance Holder's name	
Insured Date of Birth	
Insured Address	
Insured Address	
Insured City	
Insured State	
Insured ZIP	
Insured Employer’s Name	
Dental Insurance Company	
ID Number	
Group Number	
Insurance Plan Name	

Secondary Insurance Information

Do you have a secondary dental insurance?	
That's all! If you would like to add secondary insurance, you need to provide primary insurance first.	
Would you like to upload insurance card photo?	
Patient’s relationship to the Insurance Holder	
Insurance Holder's name	
Insured Date of Birth	
Insured Address	
Insured Address	
Insured City	
Insured State	
Insured ZIP	
Insured Employer’s Name	
Dental Insurance Company	
ID Number	
Group Number	
Insurance Plan Name	