Dr. Johnny L. Smith, DMD
9276 W. Union Hills Drive, Suite A
Peoria, AZ 85382
Ph: (623) 972-6137
Fax: (623) 972-6334

Patient Information

Name: _____ Preferred Name: _____

Date of Birth: _____ SSN#: _____ Sex: Male or Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Whom may we thank for referring you to our practice? _____

Emergency Contact Information

Emergency Contact Person: _____

Relationship: _____ Phone: _____

Dental History

What is the reason for your visit today? _____

What, if anything, would you do to change the appearance of your teeth? _____

_____

How long has it been since your last dental exam & x-rays? _____

When was your last dental cleaning? _____

Have you had any complications during dental treatments? If so, explain: _____

_____

Have you ever had any periodontal (gum) treatments? Yes or No (circle one)

Medical History

Are you currently under the care of a physician? Yes or No (circle one)

Name of Physician: _____ Phone: _____

Have you had a serious illness, operation or been hospitalized in the last 5 years?

Yes or No If yes, explain: _____

_____

Have you ever had any joint replacements? Yes or No If yes, explain: _____

_____

List any medications you are allergic or sensitive to: _____

List any medications you are CURRENTLY taking: _____

Have you ever had any of the following? Please check all that apply:

- o AIDS/HIV
- o Allergies/hives
- o Arthritis
- o Artificial Joints/Prosthesis
- o Artificial Heart valve/stent
- o Artificial Other
- o Asthma
- o Bisphosphonate
- o Drugs
  - Oral
  - Injection/IV
- o Blood Thinners
- o Blood Transfusion
- o Bruise easily
- o Cancer/Leukemia
- o Chemo/Radiation treatment
- o Diabetes
- o Drug addiction
- o Epilepsy/Seizures
- o Fainting/Dizzy spells
- o Heart condition
  - Heart attack
  - High/low blood pressure
  - Heart defects
  - Heart murmur
  - Pacemaker
  - Heart Surgery
- o Hemophilia
- o Hepatitis A, B, or C
- o Kidney disease/trouble
- o Liver disease/trouble
- o Mental disorders
- o Osteoporosis
- o Sexually Transmitted Diseases
- o Sinus problems
- o Stroke
- o Thyroid conditions
- o Tobacco user
  - Current
  - Past

Patient's Signature: _____ Date: _____

Parent or Guardian's Name: _____ Signature: _____

Office Policies

Financial Agreement
Payment in full for all charges is required at the time of visit, unless prior arrangements have been made.

Insurance Filing
The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

Insurance Information
Insurance Plan Name: _____ Institute Telephone: _____
Policy Holders Name: _____ Social: _____
Policy Holders DOB: _____ ID#: _____
Policy Holders Employer: _____ Group #: _____
Insurance Company Address: _____
Policy Holder's Phone: _____
Patient's Relationship to Policy Holder: _____

Assignment of Insurance Benefits
I/We hereby assign directly to Johnny L. Smith, D.M.D., P.A. all insurance benefits otherwise payable to me/us. I/We are financially responsible for charges not paid by this assignment.

Delinquent Accounts
All delinquent accounts are subject to reasonable service charges and/ or legal interest rates.

Collection Proceedings
In the event your account is turned to a collection agency for non-payment or other delinquency; you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any Account turned over to collection agency forfeits any past special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

Responsible Party Signature: _____ Date: _____

HIPAA Information:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out treatment, (including direct or indirect treatment by other healthcare providers involved in my treatment). Obtaining payment from third party payers, (e.g. insurance companies, the day to day healthcare operations of Dr Smith's Practice. I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care options, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Notice of Privacy Practices

The office of Dr. Johnny L. Smith complies with HIPAA and will not release any information about patients without their consent.

I do authorize the office of Dr. Johnny L. Smith to release personal information to family, doctors, etc.

1) _____

2) _____

I have completely read and understand the content of this agreement.

Patient Signature: _____ **Date:** _____