Grant E & Mark A Smith DDS

Drs. Mark&Grant Smith,Sharlenne Sumpter
2011 W. Lamberth Rd. • Sherman, TX 75092
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(903)893-8030

Please Review and Update any Necessary Changes

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Name and Phone Number of emergency contact: *

_____

_____

Dental Insurance

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

☐ * **If filing insurance: I am aware that all insurance amounts calculated are an estimate only and I/patient is responible for any balances on my account.**
If not filing insurance: I am aware that I am financially responsible for any fees for service that I/patient receives.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 at the time services are performed unless other arrangements are made.

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

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

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. 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 grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Payment Options are:

CASH

CHECK

MAJOR

CREDIT/DEBIT

CARD

CARE-CREDIT

☐ * **By checking this box, I understand the above information and agree with its contents and this will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I prefer to be contacted by

Cell phone/Text

Email

Home Phone

Leave a message

I authorize this dental practice to release any financial or dental information to the following person(s) listed below, if no one please reply NA: *

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet/Electronic Communications

Grant E and Mark A Smith DDS may not disclose your PHI electronically without your authorization unless allowed by law. For example, Grant E and Mark A Smith DDS may share your PHI through approved, secure electronic methods for the purpose of treatment, payment for health care services, or health care operations such as case management or care coordination. Grant E and Mark A Smith DDS may also need to share your PHI electronically for public health purposes such as preventing and controlling the spread of infectious diseases or for certain disaster relief efforts. I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice and grant the dental practice permission to securely upload my patient information to the web site.**

_____

Response Date: _____

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Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- [ ] No Medical Conditions

- [ ]
- [ ] Allergies
- [ ] Allergy-Penicillin
- [ ] Antihistimines
- [ ] Asthma
- [ ] Blood Thinners
- [ ] Cancer
- [ ] Chronic Cough
- [ ] Diabetes Type I/II
- [ ] Epilepsy/Seizures
- [ ] HIV/AIDS
- [ ] Heart Surgery/Attack
- [ ] Hip Replacement
- [ ] Liver Disease
- [ ] Nervous Disorders
- [ ] Pacemaker/Stents
- [ ] SMAS
- [ ] Stomach Problems
- [ ] Tuberculosis
- [ ] iodine
- [ ] *Pre-Med
- [ ] Allergy-Amoxicillin
- [ ] Allergy-Sulfa Drugs
- [ ] Anxiety
- [ ] Autoimmune Disease
- [ ] Blood Transfusion
- [ ] Cefdinir
- [ ] Cicatrical Pemphigol
- [ ] Doxycycline
- [ ] Excessive Bleeding
- [ ] Head/Neck/Jaw Injury
- [ ] Hemophilla
- [ ] Jaundice
- [ ] Mental Disorders
- [ ] Neurological Problem
- [ ] Pregnant/Nursing
- [ ] STD/HPV
- [ ] Stroke
- [ ] Tumors/Growths
- [ ] ADD/ADHD
- [ ] Allergy-Codeine
- [ ] Alzheimer's/Dementia
- [ ] Arthritis/Rheumatism
- [ ] Avelox
- [ ] Bone Marrow Transpla
- [ ] Chemo/Radiation
- [ ] Cold Sores/Blisters
- [ ] Dry eyes
- [ ] Fainting/Dizziness
- [ ] Heart Disease
- [ ] Hepatitis A/B/C
- [ ] Kidney Trouble
- [ ] Mitra Valve Prolapse
- [ ] OrganTransplant
- [ ] Respiratory Problems
- [ ] Sickle Cell Disease
- [ ] Swollen Ankles
- [ ] Ulcers
- [ ] Acid Reflux
- [ ] Allergy-Latex
- [ ] Anemia
- [ ] Artificial Joints
- [ ] Blood Disease
- [ ] COPD
- [ ] Chest Pains
- [ ] Cortisone Medicine
- [ ] Emphysema
- [ ] Glaucoma
- [ ] Heart Murmur
- [ ] High Blood Pressure
- [ ] Leukemia
- [ ] Moxifloxacain
- [ ] Other
- [ ] Rheumatic Fever
- [ ] Sinus Problems
- [ ] Thyroid Problems
- [ ] Xylocaine

Please clarify the conditions or alerts selected including due date if pregnant:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain. * ◯ Yes ◯ No

Pre-Med

_____

_____

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

_____

_____

Name of physician and date of last physical exam

Name and phone number of preferred pharmacy

Are you taking any medications (prescription and Non-prescription) if yes please explain below * ◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

Please check below any that apply to you:

☐ Have you taken Viagra, Revatio, Cialis or Lavitra in the last 24 hours?

☐ Have you ever taken any medications with Biophosphonates? (Fosamax, Boniva, Actonel, or others)

☐ Have you ever had an orthopedic total joint (hip, knee, elbow or finger) replacement?

Do you have any allergies and/or allergies to medications not previously listed. If yes, please explain below * ◯ Yes ◯ No

Allergies

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. Upon diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me. Lastly, I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Response Date: _____

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No Show Policy

Due to the large number of patients needing to be seen and an increasing number of appointments that are "no showed" we have been forced to implement the following policy. A "no show" appointment is when you have an appointment scheduled and do not show up or call within a reasonable time (preferably 24 hours' notice) to cancel. We understand that there are valid reasons for missing an appointment and those will be addressed on a case-by-case basis. The "no show" policy is as follows:

1st No Show: There will be a non-refundable charge of $25.00 applied to your account.
2nd No Show: There will be another non-refundable charge of $50.00 applied to your account.
3rd No Show: You will be dismissed from the practice. When this occurs, you will be notified by certified mail of your dismissal from our practice.

To prevent this from happening please contact our office as soon as you know you will be unable to keep your appointment. This will allow time for someone else to be seen by the doctor in your absence.
Please note that we do have a reminder service that will text and call you to remind you of your appointment 2 weeks prior and again 1 day prior to your scheduled date.

Thank you for your understanding.

Grant E. & Mark A. Smith DDS

☐ * **I have read and understand the above policy.**

Response Date: _____