Simply Smiles, PA

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Welcome to Simply Smiles, P.A. Dental Studio & DentiSpa

Chart#: ______________
FOR OFFICE USE ONLY

Patient Name: ______________* ______________* ____ ______________
Last First MI Preferred Name

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

Birth Date:* ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ______________________________ **Best time to call:** ______________

Phone: ____________* ____________ ____________ ______ ____________ ____________
Home Mobile Work Ext Fax Other

Address: ______________________________* ______________________________
Address 1 Address 2

______________________________* ________* _____-____*
City State Zip Code

Do you live in the Southwest Florida area full time? ◯ Yes ◯ No

Whom may we thank for referring you to our practice?

Referral Name: ______________________________

In an emergency who should be notified? Please enter Name, Phone Number and Relationship below:

Emergency Contact:

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What is your immediate concern?

____

____

Previous Dentist Name, Phone Number and reason for leaving:

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Date of most recent dental exam and dental x-rays:

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May we contact your last dental office to obtain radiographs or clinical information? ◯ Yes ◯ No

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________ **Phone:** __________

Employer Address: ______________________ ______________________

Address 1 Address 2

______________________ ____ _____-____

City State Zip Code

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or you are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________ ______________ ___ ______________

Last First MI Preferred Name

Title: ________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Mr/Ms/Mrs/etc

Birth Date: __________ **SS#:** ___-__-____ **DL#:** ______________

Email Address: ______________________ **Best time to call:** __________

Phone: ________ ________ ________ ____ ________ ________

Home Mobile Work Ext Fax Other

Address: ______________________ ______________________

Address 1 Address 2

______________________ ____ _____-____

City State Zip Code

Primary Dental Insurance:

Name of Insured: ____________________ ____________________ ____
Last First MI

Insured's Birth Date: ____________

ID #: ________________ **Group #:** ____________

Insured's Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ____

Employer Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ _____-____
City State Zip Code

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

Insurance Plan Name: ____

Insurance Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ _____-____
City State Zip Code

Insurance Company Phone Number:

____

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Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you withthe most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and education tools so that you may fully participate in maintaining oral health.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash 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 help prepare 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. Our practice is not a party to your insurance agreement.

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, or within fifteen (15) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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.

☐ * **By checking this box, I acknowledge that I have read and provided information to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. Any and all insurance pre-estimates are not binding by the insurance company and are purely estimates. No guarantee of payment is given by the insurance company. Therefore, I understand that I am ultimately responsible for all charges whether or not paid by my insurance. I authorize this signature on all insurance submissions. I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

Health History

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Levoquin	☐ *Pre-Med - Other
☐ *Pre-Med-Keflex	☐ Allergy-Amoxicillin	☐ Allergy-Aspirin	☐ Allergy-Azithromycin
☐ Allergy-Clindamycin	☐ Allergy-Codeine	☐ Allergy-Eggs	☐ Allergy-Hydrocodone
☐ Allergy-Ibuprofen	☐ Allergy-Keflex	☐ Allergy-Latex	☐ Allergy-NSAIDS
☐ Allergy-Naproxyn	☐ Allergy-Narcotics	☐ Allergy-Penicillin	☐ Allergy-Tylenol
☐ Amibig	☐ Anxiety	☐ Artificial Hrt Valve	☐ Artificial Joints
☐ Asthma	☐ Back problems	☐ Bell's palsy	☐ Bisphophate therapy
☐ Blind/eye issues	☐ Blood Disease	☐ C.O.P.D.	☐ CPAP USE
☐ Cancer	☐ Cardiovascular Issue	☐ Chemical Dependency	☐ Chemotherapy
☐ Cognitive Impairment	☐ CongestiveHeartFailu	☐ Dementia	☐ Diabetes
☐ Digestive System	☐ Ear pain/deaf	☐ Emphysema	☐ Epilepsy
☐ Fainting	☐ G.E.R.D.	☐ Glandular/Thyroid	☐ HIV
☐ Head Trauma	☐ Headaches	☐ Heart Attack	☐ Heart Disease
☐ Hepatitis	☐ High Blood Pressure	☐ Joint/Jaw Pain	☐ Kidney Disease
☐ Liver Disease	☐ Medicine Intolerance	☐ Mental Disorders	☐ Migraines
☐ Mitral Valve Prolaps	☐ Muscle/Skeletal	☐ Nervous System	☐ Pacemaker
☐ Pregnant/Nursing	☐ Prev. Endocarditis	☐ Radiation Treatment	☐ Respiratory Problems
☐ Seasonal Allergies	☐ Sinus problems	☐ Stomach Issues	☐ Stroke
☐ Tobacco Use	☐ Urinary System	☐ Vertigo	☐ xNo Drug Allergies
☐ xNo Medical Issues			

Any conditions other than above:

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

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Other Allergies (OTHER THAN LISTED ABOVE):

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Current Physician Name, Address and Phone number (Can answer NONE, if applicable)

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____

Preferred Pharmacy Name, Address and Phone Number

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Do you have any current medical treatment, impending surgery or other treatment not listed above that may affect your dental treatment? If so, please list.

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☐ * **By checking this box, I acknowledge that I understand the above information is necessary to provide me with care in a safe and efficient manner. I have answered all questions accurately and completely to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Dr. Angela Boehler or her staff of any changes in my health or medication as they should occur. This will serve as my electronic signature.**

HIPAA Acknowledgement

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 authorize Simply Smiles, P.A. to call and leave messages concerning my health care on my answering machine/voicemail. * ◯ Yes ◯ No

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

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☐ * **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 Communications

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.

☐ * **By checking this box, I acknowlege that I have read the information above regarding the secured uploading/downloading of my patient information to and from the web site for the dental practice, and grant the dental practice permission to securely upload/download my patient information to the web site and my electronic medical records.**

Consent for Use and Release of Photos

I consent and authorize Simply Smiles, P.A., and Angela M. Boehler, D.M.D. or any entity authorized by Simply Smiles, P.A. and Angela M. Boehler, D.M.D. to copyright, use and publish any of the images and/or videos with or without audio in any format taken of me. I understand these images may be used for a variety of purposes and may appear on Simply Smiles, P.A. website or social media accounts, promotional materials or any other media now known or to be invented. I also understand that Simply Smiles, P.A. and Angela M. Boehler, D.M.D. or any entity authorized by them will use the images exclusively for Simply Smiles, P.A. Dental Studio & DentiSpa related purposes and not for any commercial gain.

◯ Yes ◯ No

I give release to use my name accompanying the photo(s)/video(s), if needed. ◯ Yes ◯ No

My photo(s)/video(s) can be used but with the qualifiers I have described below. Leave blank if there are no qualifiers.

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Informed Consent for Treatment

I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.

In general terms, dental and spa services treatment may include but is not limited to one or a number of the following: Administration of local anesthesia,Cleaning or the teeth and application of topical fluoride,Scaling and root planing with local anesthesia,Treatment of diseased or injured teeth with dental restorations,The replacement of missing teeth with a dental prosthesis (crown, partials, etc.),Treatment of diseased or injured oral tissues (hard and/or soft),Treatment of malposed (crooked) teeth and/or developmental abnormalities,Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or root canal.

RISK OF DENTAL AND SPA SERVICES TREATMENT IN GENERAL
Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth. Thrombophlebitis(inflammation to a vein), reaction to injections, bruising, Vascular Occlusion (blockage of a vein), change in occlusion (biting), muscle cramps and spasms. Tempromandibular jaw (TMJ) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues. Referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination.

CHANGES IN TREATMENT PLAN
I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give me permission to the dentist to make any/all changes and additions as necessary.

FILLINGS
I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy,
resulting in additional costs.

ALTERNATIVE TREATMENT
I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

☐ * **By checking this box and signing below, I acknowledge that I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorize for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction. I have been given alternatives to treatment planned and have been told the risks and rewards of each of these alternatives as well. I further understand that this consent shall remain in effect until terminated by me.**

Patient Signature____

Date____/_____/_______ ________________________

BE CERTAIN TO ANSWER ALL QUESTIONS WITH AN ASTERICKS OTHERWISE THE FORM WILL NOT SUBMIT TO US.

ON IPAD: PLEASE PRESS THE "SAVE AND LOGOUT" TAB IN THE LOWER LEFT CORNER OF THE SCREEN WHEN YOU ARE DONE.

ON WEBSITE: HIT SUBMIT TO SEND.

Thank you!

Response Date: ___________