1710 S. Buckley Rd. Unit 8A. Denver. CO. 80017
Office|720.899.4242 Fax|720.899.4245

OUR OFFICE POLICIES

Welcome to Smilematic Dental! We are pleased to have you as a patient and to be given the opportunity to be your partner in informed dental health care. Our office policies are designed with you, the patient, in mind. It is written to answer any questions you may have regarding how our office works.

1. **Appointments**
   We are committed to providing a high standard of personalized dental care in an efficient and professional manner. Our office is open Monday through Friday, from 9:00am until 5:00pm, and Saturdays on appointment basis. A one-hour lunch break is normally taken and does vary as scheduled based upon our patients' needs for the day. We value the time our patients set aside for their dental needs; therefore, we request that patients notify us of cancellations or reschedule 24 hours prior to the scheduled dentist appointments. This allows our office to meet dental needs of other patients who are waiting for care. If an emergency occurs, as often do, and a patient is unable to attend their appointment, our office kindly requests communication that the dentist appointment will be missed and rescheduled. We understand how valuable your time is and our office strives to accommodate your scheduling needs.

2. **Cancellations**
   We request a 24-hour notice if you need to cancel or reschedule your appointment. We understand that sometimes unforeseen events require missing an appointment. However, after your second appointment canceled without notifying us 24 hours in advance, or the second time you are more than 15 minutes late, you will be subjected to a **$50** "missed appointment fee". If you were scheduled more than an hour, a **$25** additional charge per half hour will be charged.

3. **Late Policy**
   Your appointment has been reserved specifically for you. Please arrive on time for your appointment or 15 minutes early if it is your first appointment to fill out paperwork. If you are more than 15 minutes late, you may be asked to reschedule.

4. **Emergencies**
   Smilematic Dental is closed on Saturdays (if no appointment is scheduled), Sundays, and major holidays. If you have a dental emergency, please call our office as soon as possible. We will try our best to accommodate your needs. If you have an after-hours emergency, please call our office at (720)-899-4242 and leave a voicemail which will be forwarded to our doctors.

5. **Insurances**
   For your convenience, we will gladly assist you in submitting insurance claims regarding charges for care rendered in our office. However, due to the complexities of insurance contracts, we can only give you an-estimate of what your portion will be and cannot guarantee your insurance coverage. Your estimated patient portion must be paid at the time of service. We will give your insurance 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full for all payment not covered by your insurance company. If you have any questions, our staff is always available to answer your questions or concerns.

6. **Timeliness of payment**
   You are responsible for deductible and estimated co-payments at the time of service. If there is any balance left after your insurance paid your claim, we will either call and ask you to provide a payment or mail a statement to your address. The full balance is expected within 14 days. Accounts 60 to 90 days delinquent will be sent to collections and further fees will be applied appropriately.

As witness by my signature, I hereby acknowledge I have been advised of the Office Policies of Smilematic Dental.

Patient Name: ____________________________Signature:______________________________ Date:_________________

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PATIENT REGISTRATION

TODAY'S DATE: __________/__________/__________

GETTING TO KNOW YOU

How did you find us?

____

(If it was another patient of ours that referred you to us, please list their name here so we can thank them, thank you!)

Name:____
(First) (Middle) (Last)

Phone numbers: 1. (   )-   -   2. (   )-   -   3. (   )-   -
Home Cell Work

Email:________________________________ Date of Birth: _______________________
MM/DD/YYYY

Address:____
Street Address City State Zip

SSN:_____________________ ←(ONLY for insurance purposes and will be kept strictly confidential)

Emergency Contact: Name____________ Phone(   )-   -   Relationship_________

INSURANCE INFORMATION (Please provide a copy of your insurance card.)

Do you have dental insurance?............................YES_______NO_______

If YES,

Insurance Name:___________Policy Number:________________ Group Number:____________
(i.e. Aetna, Cigna, etc.) (Member ID)

Are you the plan subscriber?................................YES_______ NO_______

If NO,

Subscriber Name:_____________ DOB:__________ SSN:______________Relationship:____________
MM/DD/YYYY (To Patient)

Health History Form

Patient Name: ______________________________________ Date: ___/___/_____

Are you completing this form for another person?..YES_____ NO_____
If YES,
Your Name: ________________________ Phone: ( )- - Relationship to Patient: ______________

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Do you have…?

Active Tuberculosis..........YES_____ NO_____
Persistent cough (lasting longer than 3wks)..........YES_____NO_____
Cough that produces blood?..........YES_____ NO_____
Have you been exposed to anyone with Tuberculosis?..........YES_____NO_____

If you answered YES to any of the items above, please stop and return this form to the receptionist, thank you.

Dental Information

~Mark 'Don't Know'(DK) for questions you are unsure about, thank you.

Do your gums bleed when you brush or floss?..........YES____NO___DK___
Are your teeth sensitive to cold, hot, sweets or pressure?
..........YES____NO____DK___
Does food or floss catch between your teeth?..........YES___NO____DK___
Is your mouth dry?..........YES____NO____DK____
Have you had any periodontal(gum)treatments?..........YES____NO____DK____
Have you ever had orthodontic(braces)treatment?..........YES____NO____DK____
Have you had any problems associated with previous dental treatment?
..........YES____NO____DK____
Do you drink bottled or filtered water?..........YES____NO____DK____

- If YES, how often?..........DAILY____WEEKLY____OCCASIONALLY____

Is your home water supply fluoridated?..........YES____ NO___DK____
Are you currently experiencing dental pain or discomfort?
..........YES____NO____DK____
Do you have earaches or neck pains?..........YES____NO____DK____

Do you have any clicking, popping or discomfort in the jaw?
..........YES____ NO____DK____
Do you brux or grind your teeth?..........YES___NO____DK____
Do you have sores or ulcers in your mouth? YES____NO____DK____
Do you wear dentures or partials?..........YES___NO____ DK____
Do you participate in active recreational activities?
..........YES___NO____DK____
Have you ever had a serious injury to your head or mouth?
..........YES____NO____ DK____
Date of last dental exam:..........____/____/____
Date of last X-Rays:..........____/____/______

Please explain the reason for your visit today:

____

How do you feel about your smile?

____

Medical Information

~Mark 'Don't Know' (DK) for questions you are unsure about, thank you.

Are you now under the care of a physician?..........YES____NO____DK____

- If YES: Physicians Name:_____________________ Phone: ( )- -
  Address:____

Are you in good health?..........YES___NO___DK____
Has there been any changes in your health within the past year?
..........YES____NO____DK____

- If YES, please describe:_____________________________________

____
Date of last physical exam:..........____/____/______
Have you had a serious illness, operation, or been hospitalized in the past 5 years?..........YES____NO____DK____

- If YES, please describe: ____________________________________

____
Have you had an orthopedic total joint(hip, knee, elbow, finger) replacement?
..........YES____NO____DK____

- If YES, what was it:__________date ofsurgery:..........____/____/_____

Are you taking or scheduled to begin taking alendronate(Fosamax®) or risedronate(Actonel®) for osteoporosis or Paget's disease?...YES____NO____

Are you taking, or have you recently taken, any prescription or over-the-counter medicine(s)?..........YES___NO____DK____

- If YES, please list all, including vitamins, natural or herbal preparations and/or diet supplements:_____________________

____
____
____
____

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..........YES____NO____DK____

WOMEN ONLY –

Are you pregnant?..........YES____NO____DK____

- If YES: How many weeks are you?..........________

Are you taking birth control/hormone replacement?
..........YES____NO____DK____
Are you nursing?..........YES____NO____DK____

Medical Information (*Continued*)

ALLERGIES

Have you ever experienced a reaction/are you allergic to:

- Local Anesthetics……YES____ NO____ DK____
- Aspirin ……YES____ NO____DK____
- Penicillin or other antibiotics……YES____ NO____DK____
- Barbiturates, sedatives, or sleeping pills ……YES____ NO____ DK____
- Sulfa drugs……YES____ NO____ DK____
- Codeine or other narcotics……YES____ NO____DK____
- Metals……YES____ NO____ DK____
- Latex(rubber)……YES____ NO____ DK____
- Iodine……YES____ NO____ DK____
- Hay fever/seasonal……YES____ NO____ DK____
- Animals……YES____ NO____ DK____
- Food……YES____ NO____ DK____
- Other……YES____ NO____ DK____
  - If YES, please describe:________________________

____

____

Do You Have…?

Artificial(prosthetic) heart valve……YES____ NO____ DK____
Previous infective endocarditis……YES____ NO____ DK____
Damaged valves in transplanted heart..YES____ NO___DK____
Congenital heart disease(CHD)……YES____ NO____DK____
Unrepaired, cyanotic CHD……YES____ NO____DK____
Repaired(completely) in last 6 months..YES____ NO___DK____
Repaired CHD with residual defects……YES____ NO___DK____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
……YES____ NO____ DK___

- If YES, name of physician/dentist making recommendation ____
- If YES, what was recommended?______________________

Do you have any disease, condition, or problem not listed above that you think I should know about?
……YES____ NO____ DK___

- If YES, please explain:________________________________

____

____

____

____

____

____

FOR COMPLETION BY DENTIST

Comments:

____

____

____

____

____

____

Do you use controlled substances(drugs)……YES____ NO___DK_____
Do you use tobacco(smoking, snuff, chew, bidis)?……YES____ NO___DK_____

- If YES, how interested are you in stopping?
  circle one……VERY…SOMEWHAT…NOTINTERESTED……

Do you drink alcoholic beverages?……YES____ NO___DK____

- If YES, how much alcohol have you had within the past 24hrs?____
  How much do you typically drink in a week?
  ____

Do you wear contact lenses?……YES____ NO___DK_____

Have you ever had or experienced…?

Angina……Y____ N____DK____
Arteriosclerosis…Y____N____DK____
Heart attack……Y____N____DK____
Heart murmur……Y____N____ DK____
Pacemaker……Y____N____ DK____
Rheumatic fever..Y____N____ DK____
Anemia……Y____ N____ DK____
Hemophilia……Y____ N____ DK____
Arthritis……Y____ N____ DK____
Asthma……Y____ N____ DK____
Bronchitis……Y____ N____ DK____

Emphysema……Y____ N____ DK____
Sinus trouble……Y____ N____ DK____
Tuberculosis……Y____ N____ DK____
Chronic pain……Y____ N____DK____
Eating disorder……Y____ N____DK____
Malnutrition ……Y____ N____DK____
Ulcers……Y____ N____ DK____
Stroke……Y____ N____ DK____
Glaucoma ……Y____ N____DK____
Epilepsy……Y____ N____ DK____
Night sweats……Y____ N____ DK____

Blood transfusion……Y___N___DK___ If Y, date:______/______/_____________
Neurological disorders……Y___N___DK___ If Y, please specify_________________
Mental health disorders……Y___N___DK___ If Y, please specify_________________
Recurrent infections……Y___N___DK___ If Y, please specify_________________
Other congenital heart defects……YES___NO___DK___

- If YES, please specify____

Chest pain upon exertion……YES___ NO___DK___
Diabetes type I or II……YES___ NO___DK___
Gastrointestinal disease……YES___ NO___DK___
G.E. Reflux/persistent heartburn……YES___ NO___DK___
Thyroid problems……YES___ NO___ DK___
Hepatitis, jaundice or liver disease……YES___ NO__DK___
Fainting spells or seizures……YES___ NO___DK___
Sleep disorder……YES___ NO___ DK___
Kidney problems……YES___ NO___ DK___
Osteoporosis……YES___ NO___ DK___
Persistent swollen glands in neck……YES___ NO___DK___
Severe headaches/migraines……YES___ NO___ DK___
Severe or rapid weight loss……YES___ NO___DK___
Sexually transmitted disease……YES___ NO___DK___
Excessive urination……YES___ NO___ DK___
Cardiovascular disease……YES___ NO___ DK___
Congestive heart failure……YES___ NO___DK___
Damaged heart valves……YES___ NO___DK___
Low blood pressure……YES___ NO___DK___
High blood pressure……YES___ NO___DK___
Mitral valve prolapse……YES___ NO___DK___
Rheumatic heart disease……YES___ NO___DK___
Abnormal bleeding ……YES___ NO___DK___
AIDS or HIV infection……YES___ NO__DK___
Autoimmune disease……YES___ NO___DK___
Rheumatoid arthritis……YES___ NO___DK___
Systemic lupus erythematosus……YES___ NO___DK___
Cancer/Chemotherapy/Radiation treatment……YES___ NO___ DK___
Chest pain upon exertion……YES___ NO__DK___

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient/legal guardian:_____________________________________ Today's Date:______/______/________

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Office|720.899.4242 Fax|720.899.4245

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14,2003. Smilematic Dental recognizes our obligation to protect the privacy of health information that we create, receive, maintain, or transmit. We are committed to protecting your health information. We create record of the care and services you receive at our offices. We need this record to provide you with quality care to comply with certain legal requirements. This notice applies to all of the records of your care generated or kept by our dentists, hygienists and other staff. This notice will tell you about the ways we may use and disclose your health information. We also describe rights and certain obligations we have concerning the use and disclosure of your health information.

We are required by law to:

1. Ensure that health information that identifies you is kept private;
2. Give you this notice of our legal duties and private practices with respect to health information about you; and
3. Follow the terms of this notice that is currently in effect, as we may change it from time to time.

How We May Use and Disclose Your Health Information

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For treatment: We may use your health information to provide you with dental treatment or services. We may disclose health information about you to dentist, dental assistants, hygienists, other dental office personnel or other health care providers who are involved in your treatment or care. For example, your dentist may need to disclose some of your health information to order tests or lab work to be performed at an outside laboratory or other outside health care provider, or your dentist may need to disclose health information to people outside the office who may be involved in your dental or health care after you leave the dental office, such as family members.

For payment: We may use and disclose health information about your treatment and services to bill and collect from you, your insurance company or a third-party payer. For example, we may need to give your dental/health insurance plan information so that it will pay us or reimburse you for dental services. We may also tell your health insurance plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: We may use and disclose your health information for office operations. These uses and disclosures are necessary to run our dental office and make sure that all of our patients receive quality care. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. Some of these reviews may be conducted by independent dentists who are members of our staff but are not employees of the office. We may also combine health information about may of our patients to decide what additional services we should offer and what services are not needed. We may also combine health information we have with health information from other dental practices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Individuals Involved in Your Care or Payment: We may disclose your health information to a member of your family, your friend or another individual who is directly involved in your care and the disclosure is necessary for your welfare. The practice will limit the health information disclosed to a family member, friend, or other individual to health-related signs and symptoms and to information designed to help you deal with your condition or treatment, including setting and changing appointments, receiving instructions or post-visit care or picking up treatment-related items. We may also disclose a limited amount of your health information to locate you or to locate or notify your family member or friend. We may also give information to someone who helps pay for your care. We will not make these disclosures to your friends and family if you tell us not to.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Workers Compensation: We may release your health information for workers' compensation or similar programs, these programs provide benefits for work-related injuries or illness. Your written authorization to this release is required, however, if you do not consent release of information, your workers' compensation benefits may be denied, and you will be responsible for the costs of your dental care.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official: In response to a court order, subpoena, warrant, summons or similar process, to identify or locate a suspect, fugitive, material witness or missing person. About a victim of a crime if under certain limited circumstances, we are unable to obtain the persons' agreement about a death we believe may be the result of criminal conduct, about a criminal conduct at the hospital and in an emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of the hospital to funeral directors as necessary to carry out their duties.

Permission from you: Other uses and disclosures of health information not covered in the above categories will be made only with your permission. You may give permission with a written consent or authorization. If you provide us permission to use or disclose health information about you, you may revoke that permission at any time orally or in writing. If you revoke permission, we will no longer use or disclose health information about you to the extent your permission is needed for the use or disclosure. You understand that we are unable to take back any disclosures we have already made with your permission and that we required to retain our records of the care that we provided to you.

Your Health Information Rights.

You have the following rights concerning health information we maintain about you:

Right to Inspect and Copy Your Health Information: You have the right to inspect and copy your health information and to receive a written summary or explanation of your health information if you make a request in writing by completing our records authorization form and you will be provided the information and copy of records within 72 hours after the administrative fee and authorization form are completed. If you want to inspect, copy or receive this information, please contact the privacy officer listed at the end of this notice to obtain and complete the required form. If you request copy of your health information, we will charge you a fee for the costs of copying, mailing, compiling and/or printing your request or of preparing a written summary or explanation, as well as for administrative fee that will cover labor costs. We may deny your request in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Receive your Health Information in Electronic Form: If you make a request on or after February 17,2010 for an electronic copy of the health information that we maintain in electronic form, we will provide the information in electronic form to you or directly to a third party of your choice. For providing an electronic copy of your health information, we will charge you our labor costs in responding to your request.

Right to Ask for Changes in Health Information: If you feel that health information, we have about you is incorrect or incomplete, you may ask us to change or add to the information. You have the right to ask for a change or addition for as long as the information is kept by the office. You should contact the privacy officer listed at the end of this notice to get the form you will need to ask for a change or addition. You must give us a reason for your request. We may deny your request for a change or addition to your health information if it is not in writing or does not include an appropriate reason to support the request. In addition, we may deny your request if you ask us to change or add to information that: we did not create, unless the person or entity that created the information is no longer available to make the change or addition, is not part of the health information kept by the office, is not part of the information which you would be permitted to inspect and copy or is already accurate and complete.

Right to Request Restrictions: You have the right to request a restriction of limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny your request. We do not have to agree to the restrictions that you request, but if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you should contact the privacy officer at the address or number listed at the end of this notice to get the form you will need to fill out for this purpose. In your request, you must tell us: what information you want to limit, whether you want to limit our use, disclosure or both and to whom you want the limits to apply(for example, your spouse, your children, your parents or others involved in your care). To be binding on us, any agreement to comply with special restrictions must be in writing signed by the privacy officer for our office.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the privacy officer listed at the end of this notice. We will not ask you the reason for your request. We will accommodate all responsible requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the privacy officer listed at the end of this notice or ask any of our staff members.

Right to be Notified of Breach of Security: You have the right to be notified if there is a security breach with respect to your protected health information. In the event of such a breach, we will notify you directly in writing or, if your contact information is out of date, we will take steps to notify you by other means, such as posting to our website or notices in print or broadcast media.

Changes to this Notice: We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. The current notice will be posted in our dental offices and we will include the effective date.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our dental office or with the Secretary of the Department of Health and Human Services, To file a complaint, contact the privacy officer listed at the end of this notice or ask any of our staff members. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Privacy Officer and Contact Information: Smilematic Dental Privacy manager, mailing address: 1710 South Buckley Road, Unit 8A. Aurora, Colorado. 80017. (720)899-4242.

As witness by my signature, I hereby acknowledge I have been advised of the Office polices of Smilematic Dental.

Patient Name:______________________________ Signature:_____________________________________ Date:________________