



PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____
How do you wish to be addressed? _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Telephone (Mobile) _____ (Work) _____ (Home) _____
Email _____
How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY (If minor)

Last Name: _____ First: _____ Initial: _____
Address (If different) _____ Date of Birth _____
City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____ (Mobile) _____
Email _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Initial: _____
Telephone (☐ Mobile ☐ Work ☐ Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text to 98269. Go to www.greatexpressions.com for more information.

I attest to the accuracy of the information on this page.

Signature _____ Date _____
(Responsible Party, if under 18)

PATIENT REGISTRATION



PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ PATIENT FIRST NAME: _____

DENTAL HISTORY

Reason for today's visit _____		Date of last dental visit _____	
Former dentist _____		Date of last dental x-rays _____	
Please check if you have/had:			
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Head, neck, jaw pain, or aches	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure or irritants	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	(cold, heat, sweets)	
<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____	
<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____	

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐ Yes ☐ No

If Yes, please explain _____

Have you ever had trouble from previous dental care? ☐ Yes ☐ No If Yes, please explain _____

MEDICAL HISTORY

Physician's name _____		Date of last visit _____	
Physician's address _____		Blood Pressure _____	
Have you had any serious illnesses or operations Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe _____			
Have you ever had a blood transfusion Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give approximate dates _____			
(Women) Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Due date _____ Nursing? Yes <input type="checkbox"/> No <input type="checkbox"/> Taking birth control pills? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Please check if you have/had:			
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, hay fever, sinusitis	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis type _____	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Required Hospitalization	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Any immune deficiency	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Have you used steroids	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Date of last episode _____	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding abnormally with operations or surgery	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood disease, clotting disorders	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependency	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatments	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone treatments	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cough, persistent or bloody	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Slow Healing Wounds	<input type="checkbox"/>

Stroke ☐

Swelling of feet or ankles ☐

Thyroid problems ☐

Tonsillitis ☐

Tuberculosis ☐

Tumor or growth on head/neck ☐

Ulcer ☐

Have you ever/Do you take diet drugs? ☐

Weight loss, unexplained ☐

Do you wear contact lenses? ☐

Do you consume alcoholic beverages? ☐

Are you currently under the care of a Physician? ☐

Are you allergic/sensitive to Latex? ☐

Allergic to Penicillin, Aspirin, or other drugs? ☐

If Yes, please specify _____ ☐

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐

List any medications that you are taking: _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____	Date _____
Reviewed by: _____	Date _____

MEDICAL HEALTH HISTORY – UPDATE AND EXCEPTIONS

I have read my medical history and confirm that it adequately states past and present conditions

[illegible]



SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: Smile Magic Dentistry Headquarters
Telephone: 714-974-4332
Address: 505 Villa Real Drive, Suite 101-B, Anaheim Hills, CA 92807

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

Doctor Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

PRIVACY PRACTICES RECEIPT / CONSENT FORM



NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters).

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in

writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Organizations

This Notice of Privacy applies to all affiliated entities doing business as Smile Magic Dentistry.

Contact

Dr. Raihan Nazir
Compliance Officer

Smile Magic Dentistry
505 Villa Real Drive, Suite 101-B, Anaheim, CA 92807
Phone: 714-974-4332
Email: info@smilemagicdentistry.com

Effective Date of this Notice: October 19, 2018

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I, _____, understand that by signing this Consent form, I am giving my consent to Smile Magic Dentistry to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: _____

Relationship: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

Patient's Signature (Legal Guardian, if Patient is a minor)

Date:

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Smile Magic Dentistry restrict the disclosure of my PHI to those specified below:

Name: _____

Name: _____

Signature: _____ Date: _____

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____



PATIENT NAME: _____ DATE: _____

Smile Magic Dentistry is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.
- GEDC PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

INSURANCE

Smile Magic Dentistry provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Smile Magic Dentistry staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to GEDC. However, if you are paid by the insurance company instead of Smile Magic Dentistry, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

MEDICARE/ MEDICAID/ CHAMPUS/ WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Champus, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the Smile Magic Dentistry office on the date of service.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of \$25.00.

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of \$35.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____ Date _____

White Copy – Patient

Yellow Copy – Office/Chart

FINANCIAL POLICY