Nephi Smiles Family Dentistry
(435)580-5055
54 N. Main Street, Nephi UT 84648
www.NephiSmiles.com

Patient Information Form

Patient's Name: ____________ **Birth Date:** ____________ **Today's Date:** ____________

Address: ____________ **Social Security No.:** ____________

City, State, Zip: ____________ **Email:** ____________

Home/Cell Phone: ____________ **Work Phone:** ____________ **Marital Status:** ____________

Responsible Party: ____________ **Home Phone:** ____________

Responsible Party's Birthday: ____________ **Responsible Party's Social Security No:** ____________

How did you hear about us? ____________ **Responsible Party's Work Place:** ____________

Pharmacy: ____________ **Pharmacy Phone:** ____________

Insurance Company: ____________ **Group #:** ____________

Subscriber ID: ____________

Sex: ☐

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height:
		For Office Use Only BP ☐ Heart Rate: ☐	Weight:

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Alcohol Abuse	☐	☐	Hay Fever	☐	☐	Thyroid Problems
☐	☐	Allergies	☐	☐	Heart Attack	☐	☐	Tuberculosis
☐	☐	Anemia	☐	☐	Heart Surgery	☐	☐	Ulcers
☐	☐	Angina Pectoris	☐	☐	Hemophilia	☐	☐	Venereal Disease
☐	☐	Arthritis	☐	☐	Hepatitis A	☐	☐	Yellow Jaundice
☐	☐	Artificial Bones	☐	☐	Hepatitis B			
☐	☐	Artificial Heart Valve	☐	☐	High Blood Pressure			
☐	☐	Asthma	☐	☐	HIV+ AIDS	**Y**	**N**	**Allergies**
☐	☐	Blood Transfusion	☐	☐	Kidney Problems	☐	☐	Aspirin
☐	☐	Cancer- Chemotherapy	☐	☐	Liver Disease	☐	☐	Codeine
☐	☐	Colitis	☐	☐	Low Blood Pressure	☐	☐	Dental Anesthetics
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse	☐	☐	Erythromycin
☐	☐	Cosmetic Surgery	☐	☐	Pace Maker	☐	☐	Jewelry
☐	☐	Diabetes	☐	☐	Pneumocystitis	☐	☐	Latex
☐	☐	Difficulty Breathing	☐	☐	Psychiatric Problems	☐	☐	Metals
☐	☐	Drug Abuse	☐	☐	Radiation Therapy	☐	☐	Penicillin
☐	☐	Emphysema	☐	☐	Rheumatic Fever	☐	☐	Tetracycline
☐	☐	Epilepsy	☐	☐	Seizures			Other
☐	☐	Fainting Spells	☐	☐	Shingles			____________
☐	☐	Fever Blisters	☐	☐	Sickle Cell Disease			____________
☐	☐	Frequent Headaches	☐	☐	Sinus Problems			____________

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...

Notes:

Dental History

Reason for Visit: ____

Date of Last Dental Visit: ____

Please Check all that apply:

	TMJ/pain in jaw joint		Gum Recession		Sensitivity to sweets
	Gums bleed easily		Orthodontic treatment		Periodontal/gum treatment
	Broken teeth or fillings		Sensitivity to hot and/or cold		Sores/lumps in or near mouth
	Pain/aching in teeth		Clench or grind teeth		Dentures or partials
	Frequent headaches		Clicking/jaw popping		

Signature: ____ **Date:** ____________________

(If under 18, Parent or Guardian Signature Required)

Financial Policy

1. We accept cash, checks, Visa, Mastercard, American Express and Care Credit.
2. A fee of $45 will be charged for any returned check.
3. Your estimated portion of service is due the day of service. We will bill your insurance company, and upon processing will bill if further balance is due. We will also promptly refund money if our initial estimation was inaccurate.
4. Any balance over 60 days will be subject to a collection fee and will then be turned over to a collection agency unless previous arrangements have been made.
5. You understand that you forfiet any discounts given if the account is past due.

Privacy Policy

I have been given the opportunity to evaluate the privacy policies of Nephi Smiles. A separate form regarding my patient rights, as pertains to the rules and regulations of HIPAA (Health Insurance Portability and Accountability Act), has been provided to me (available online or at check-in, as well as upon request). I authorize Nephi Smiles to use or release my health information to third party payers or other health practitioners as reasonably necessary for my treatment and reimbursement therof.

I assume all financial responsibilty for all patients listed below. I understand that any treatment plan given is an estimate ONLY based on insurance information.

I, the patient or responsible party, understand and agree to the above office policies.

Responsible Party (Please Print): ____

Responsible Party Signature: ____________________________________Date______________

Patients covered under this policy:

____

____

____

____

____

____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ____________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

___________________________________ ___________________________________

Please ***print*** name of Patient(s) Please ***sign*** for Patient(s) / Guardian of Patient(s)

___________________________________ ___________________________________

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Any other additional family members covered by this agreement: ____

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ____________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ___________________________ Relationship: _______________________________

Name: ___________________________ Relationship: _______________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____ ______________________________________ Signature of Privacy Officer