Upward Smiles™ | ADULT Patient Information Disclosure

Patient Name: _____ Date of Birth: ____/____/_____

MoHealthNet ID Number: _____ Circle One: Male Female

Address: _____ City: _____ Zip Code: _____

Phone #1: _____ Phone #2: _____

Email: _____ (used for e-confirm, newsletters, and patient correspondence)

Employer: _____ Work Number: _____

Dental History

Is this your first visit to the dentist? YES NO If no, how long since last visit? _____

Previous Dentist's Name: _____ Were x-rays taken at previous dental visits? YES NO

Have there been any injuries to the teeth, face or mouth? YES, explain: _____ NO

Have you ever had a problem associated with dental work? YES, explain: _____ NO

Is your home tap water fluoridated? YES NO Are you taking fluoride supplements? YES NO

Have you ever had any pain or tenderness in your jaw or jaw joint? YES NO

How often do you brush per day? _____ Do you floss daily? YES NO

Medical Information:

Physician: _____Phone Number: _____

Are you currently under the care of a physician? YES NO

Have you had any hospital stays in the last 5 years? YES NO

Explain: _____

Please discuss any serious medical conditions that you have had:

_____

Do you currently have or have had in the past any of these conditions?					
Abnormal Bleeding	YES	NO	Cancer/Leukemia	YES	NO
Disabilities/Special Needs	YES	NO	Hepatitis A, B, or C	YES	NO
ADD	YES	NO	LATEX ALLERGY	YES	NO
Hearing Impairment	YES	NO	Diabetes I or II (Last A1c: __)	YES	NO
ADHD	YES	NO	Congenital Birth Defects	YES	NO
Kidney/Liver Conditions	YES	NO	HIV/AIDS	YES	NO
Autism/Aspergers	YES	NO	Convulsions/Epilepsy	YES	NO
Heart Disease/Surgeries	YES	NO	Bone Disorders	YES	NO
Asthma	YES	NO	Tobacco/Substance Abuse	YES	NO
Hemophilia/Blood Disorders	YES	NO	Lactose Intolerant	YES	NO
Tuberculosis	YES	NO	Rheumatic/Scarlet Fever	YES	NO
Pregnant	YES	NO	Been sedated for dentistry?	YES	NO

I have reviewed the above information and provided accurate information. I agree to all policies set forth and understand the entirety of the information provided. INITIAL: _____

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Please list all drugs you are currently taking:

_____

Please list all **drugs or foods** you are **allergic** to:

_____

Have you been told by a **doctor** that you need **antibiotic premedication before dental treatment**? YES NO

***PLEASE READ FULLY - General Office Policies – PLEASE READ FULLY ***

- We will attempt to confirm an appointment multiple times the week of the appointment.
- We NEED to hear confirmation from you either by speaking to the receptionist or by voicemail that you will be coming to your appointment. You can also email our office to confirm the appointment. We require confirmation no later than 3 PM the day prior to the appointment.
- If we have not been informed of reachable phone numbers and have received no confirmation for the appointment we are confirming, it is our office policy to consider that appointment CANCELLED.
- **Upward Smiles** (the "Practice") does not tolerate abusive or disruptive behavior or foul language. Patients/Parent/Guardian exhibiting such behavior will be dismissed from the practice. Threats are taken seriously and will be turned over to the local Police Department.

Contact and Voicemail Policy

The Upward Smiles staff will need to contact you to confirm your appointment date, make appointment schedule changes, or return any of your phone calls. In order to make this process more efficient and productive, we would like to contact you by telephone. By signing this authorization, you give us permission to contact you by phone. You are also acknowledging you are aware that "Upward Smiles" will appear on any caller ID device you may have. Any phone number that you provide us via verbal or written correspondence will be used to contact you. For example: if we attempt to call your home and mobile number to confirm an appointment unsuccessfully, we will call your work or alternative phone numbers. Any phone numbers you do not wish to be called should not be provided to us. In the event of an unanswered call, we will leave voice messages on any number that you provide to us, unless you notify us in writing not to do so. We will send correspondence via email to any email address you provide us. By providing an email address, you authorize us to send HIPAA covered patient information via email in regards to appointments, treatment plans, and continuing care. We can cancel this correspondence at any time, so long as you notify our office in writing that you would like to cancel electronic communications.

Late/Cancellation/Missed Appointment Policy

As a courtesy to all patients, we will re-schedule any patient who is more than 15 minutes late for an appointment.

We kindly ask that you give our office at least 24 hours advance notice prior to canceling or changing your appointment. Patients that give 24 hours are given priority when being rescheduled. If you give a same-day notice of non-attendance as the scheduled appointment, the appointment is considered "broken". No shows are also considered "broken". The first broken appointment will automatically cancel future appointments for 3 months. This means you or your child will NOT be able to be seen for 3 months unless there is an emergent concern or medical issue. The same protocol is effective for the second broken appointment. Three recorded missed or broken appointments in a patient's history will result in dismissal from the practice, except when prohibited by law. This means that you will not be seen by the Practice, and will have to receive care from another office. We are unable to make exceptions to this policy.

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize Upward Smiles, Inc. to use and disclose my protected health information to carry out:

• Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

I have reviewed the above information and provided accurate information. I agree to all policies set forth and understand the entirety of the information provided. INITIAL: _____

- Obtaining payment from third party payers (e.g. insurance company)
- Day-to-day healthcare operations of the practice (email/ text reminders/ confirmations of appointments via online services)

I have also been informed of, and given the right to review a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Upward Smiles, Inc. reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

THERE ARE RISKS TO RECEIVING DENTAL TREATMENT DURING PREGNANCY. FOR PREGNANT PATIENTS, WE REQUIRE THAT YOUR PRIMARY CARE PROVIDER SUPPLIES OUR OFFICE WITH A RELEASE STATING YOUR MEDICAL SITUATION ALONG WITH YOUR SPECIFIC CLEARANCE FOR CERTAIN PRESCRIPTIONS AND PROCEDURES. IF THIS RELEASE IS NOT PROVIDED, WE MAY NOT BE ABLE TO TREAT YOU IN OUR OFFICE. IT IS YOUR RESPONSIBILITY TO MAINTAIN REGULAR VISITS WITH YOUR PRIMARY CARE PROVIDER TO MONITOR YOUR MEDICAL STATUS.

I CERTIFY THAT I HAVE REVIEWED PAGES 1 through 3 of this patient information disclosure on the date below, and I understand and agree to any and all policies set forth. The information provided on this paperwork is to the best of my knowledge and I will not hold Upward Smiles, Inc. responsible for any errors/omissions that I on these forms.

PRINT NAME: _____

SIGN: _____ DATE: _____/_____/_____