SMILES BY HAZEN

New Patient Information

Patients Name: _____ DOB: _____

Cell: _____ Home: _____ Work: _____

Address: _____

SS#: _____ Emergency Contact: _____

Email: _____ Employer: _____

◯ Heart Problems	◯ Pregnant?	◯ Blood Thinners?	◯ Stroke
◯ High Blood Pressure	◯ Allergy to Anesthetics	◯ Measles	◯ Typhoid Fever
◯ Low Blood Pressure	◯ Allergies to Medication?	◯ Mumps	◯ Tonsillitis
◯ Circulatory Problems	◯ Anemia	◯ Psychiatric Care	◯ Tuberculosis
◯ Nervous Problems	◯ Arthritis	◯ Rheumatic Fever	◯ Ulcer
◯ Radiation Treatments	◯ Asthma	◯ Scarlet Fever	◯ Artificial Joints
◯ Excessive Bleeding	◯ Diabetes	◯ Sinus Problems	◯ Verified By:

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment?

ARE YOU ALLERGIC TO ANY MEDICATIONS?

◯ PENICILLIN ◯ CODEINE ◯ ASPIRIN ◯ NOVOCAINE ◯ OTHER: _____

HAVE YOU EVER TESTED POSITIVE FOR:

◯ HEPATITIS ◯ AIDS/HIV ◯ VENEREAL DISEASE

LIST OF CURRENT MEDICATIONS: _____

PHARMACY PREFERENCE: _____ **PHARMACY PHONE #:** _____

PHYSICIANS NAME: _____ **PHYSICIANS PHONE #:** _____

SIGNATURE: _____ **DATE:** _____

ASSIGNMENT OF BENEFITS

I authorize payment of any dental benefits to the named provider for professional services rendered. INITIAL: _____

RELEASE INFORMATION

I authorize the release of any dental information necessary to proceed with dental claim if insurance is being used. INITIAL: _____

In an emergency who should be notified? Please enter Name and Phone number below:

Responsible Party Information:

This ONLY needs to be completed if the insurance subscriber is not the patient, and/or you are the parent/guardian of the patient

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

Name: Last | First | MI | Preferred Name

Title: (Mr/Ms/Mrs/etc) Gender: ◡ Male ◡ Female Family Status: ◡ Married ◡ Single ◡ Child ◡ Other

Birth Date: SS #. Driver's License #:

Email Address: Best time to call:

Phone: Home | Work | Ext | Mobile | Fax | Other

Address:

City | State | Zip Code

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.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

Name of person completing this form:

Relationship to patient:

◯ Self ◯ Parent ◯ Spouse ◯ Guardian ◯ Other

Response Date:

SMILES BY HAZEN

19001 US Hwy 441 Mount Dora, FL 32757
352.383.9406 Smilesbyhazen@gmail.com

Informed Consent for Treatment

Dr. Hazen's Guarantee: I understand that treatment of dental conditions requiring crowns, bridges, veneers, or fillings includes certain risks and possible unsuccessful results, including the possibility of failure. Even though care and diligence is exercised in treatment of conditions requiring crowns, bridges, veneers or fillings, there are no promises and guarantee of anticipated results or longevity of the treatment, except the following: If patient keeps excellent oral hygiene and at least 2 cleaning appointments a year, Dr.Hazen will guarantee crowns, bridges, veneers and fillings for 2 years from the completion date. I understand that if I have new decay on this tooth and this restoration fails then this guarantee does not apply.

Patient Maintenance Obligation: For successful treatment results and to lessen the dangers of complication, I agree to keep excellent oral hygiene and two cleanings per year unless indicated otherwise by Dr.Hazen. It is typical to need one to multiple follow-up visits for bite and/or other adjustments. I agree and understand that it is my responsibility to notify Smiles By Hazen, PA at the soonest moment in the event that I experience pain or discomfort that I believe may be related to the indicated treatment. I agree to strictly keep ALL of my post op and cleaning appointments as well as follow other precautions and recommendations provided to me by Dr.Hazen and her staff as part of pre-treatment and post-treatment instructions. I, as the patient agree to follow to the letter what Dr. Hazen or staff members prescribe and/or administer for relief of discomfort and rectify any complication. I understand that it is not uncommon for follow up visits to be necessary to finalize restorations and adjust my bite to ideal. I agree that I will appear for all appointments needed to remedy complications or forfeit any right to dispute. I understand that this process is a surgery and that all patients respond differently and I will do all that is expected of me to have my healing process progress quickly and predictably.

Specific Results: I understand that natural teeth themselves are not "perfect" and contain certain embrasures, striations, irregulations, asymmetries, limitations, and color variations. Dr. Hazen will use her experience and artistic skills to specify the shades, coloring, shape, and sculpting of restorations to make what are very realistic replicas of teeth. As with any type artistic endeavor, however, aesthetics is a highly subjective perception. Once I commence with the final delivery of crowns, bridges, and veneers I am agreeing and consenting to the shape and shade of my tooth.

Reduction of Tooth Structure: I understand that in order to replace decayed or otherwise traumatized teeth it is necessary to modify the existing tooth or teeth so that crowns, bridges, veneers and fillings may be placed upon them. Tooth preparation will be done as conservatively as possible.

Custom Preparation of Tooth Structure: Each person is unique and presents a different set of circumstances. Some of these circumstances may not be revealed until the procedure has commenced. I understand that the exact nature of my tooth and gum preparation for my treatment plan may vary slightly from tooth to tooth and may vary from the general descriptions at my initial exam. As a result of these and other reasons, the exact nature, contours, and preparation of my teeth, bite and other circumstances may be altered during the procedure and the resulting restorations may be modified. The enamel and dentin of the tooth will be permanently altered and once prepared I understand that the tooth cannot be returned to its original state. During the course of treatment, unknown or unforeseen conditions may be revealed that necessitate a modification of the treatment plan and possible new procedures included but not limited to root canal treatment, extraction, crown lengthening, gingivectomy and indirect pulp cap. Dr. Hazen will exercise her professional judgment to perform a conservative preparation of my tooth and to make other necessary decisions regarding the means, manner and method of any procedures as she deems appropriate to achieve the desired results of my treatment plan.

Sensitivity & Comfort: I understand that the preparation of my tooth for restorative work can result in sensitivity that can range from mild to severe. This sensitivity may last for a very short time or for much longer periods. Cold sensitivity that goes away very quickly is the most common and sensitive tooth paste is recommended to help with this sensation. I understand that if I have discomfort or pain that lasts longer than 15 seconds, that is throbbing, pulsating or wakes me up in the middle of the night, that this is not a normal sensation and that I may need a root canal. It is my responsibility to contact Smile Expressions Family Dentistry to coordinate the appropriate appointments and procedures.

Temporary Restorations: Temporary crowns, bridges, and veneers are fabricated in the office or at a dental laboratory and are temporarily cemented in place until the permanent restoration is completed. It is recommended to try and avoid vigorous chewing, biting, clenching, flossing, and water flossing in the area where a temporary is cemented. If my temporary comes off I will attempt to put it back on using a pea sized amount of Vaseline, toothpaste, Fixodent, or temporary tooth cement and if it doesn't stay in place then I assume responsibility to contact Smiles By Hazen, PA @ 352.383.9406 and have it re-cemented. I understand that If my temporary comes off and I do not put it back on then my teeth can shift resulting in a possibility that my permanent restoration will not fit and it will become my financial responsibility to repeat the original procedure and have a new permanent restoration made. I will comply with all post-operative instructions given to me by Dr. Hazen and/or staff if my restorative treatment includes the need for me to wear a temporary crown, bridge, or veneer until my permanent restoration is completed.

Patient Name (please print):_____ Date: _____

Patient or legal guardian Signature: _____ Date: _____

Financial Policy

Smiles By Hazen, PA 352.383.9406

Thank you for choosing our privately owned and operated dental practice. We are happy to have you as part of our Dental Family! At Smiles By Hazen, PA, our goal is to provide you with outstanding customer service in a state of the art facility with the most up to date technology that dentistry has to offer! We hope to have you and your family members as our patients for life. We encourage you to ask questions regarding your dental treatment, and we will do our very best to educate you, and use your dental benefits as necessary.

Please read the following statements regarding your treatment and dental benefits below:

- Dr. Hazen bases her diagnosis and treatment plan according to the patient's dental necessity, and not based on what the insurance covers.
- Dental Insurance is not there to pay 100% of your dental treatment. Dental Insurance is designed to aid in the cost of your overall treatment. Dental Insurance does not cover everything!
- When given a treatment plan by Dr. Hazen or an associate of Smiles By Hazen, PA, think of your treatment plan as a prescription written by the Doctor. The staff does not have the authority to change the treatment prescribed. *Example: The Type of Cleaning the Doctor has Prescribed*
- Treatment plans **ARE NOT A GUARANTEE OF PAYMENT**, they are considered an outline of your treatment & an estimate of what your insurance may cover. All dental plans have hidden clauses that are not evident to the patient or the dental staff. Although we strive to provide an accurate estimate, we are not responsible for hidden clauses the insurance company may use when processing a claim.
- It is the responsibility of the patient to inform our office of the Age of Existing Dental Treatment when pertaining to submission of claims. IE: Replacement Periods
- Smiles By Hazen, PA will always submit our office fees (UCR) on the dental claim form **as requested by insurance companies as part of our dental contract.**
- Your insurance carrier dictates the fees that we present to you. Your treatment plan will reflect the fees provided to our office by your insurance company.
- If you have two dental insurances: Treatment plan will be based on the primary insurance coverage (*which is specified by your insurance carrier*), and as a courtesy we will submit the secondary claim for you once the primary insurance has paid, along with a copy of the Explanation of Benefits. Your secondary plan will reimburse the patient directly, and Smiles By Hazen, PA will not be held responsible or accountable for the follow up of any secondary claims or payments.
- If for any reason your treatment plan changes based on dental necessity, you will be notified immediately of the change, and a new treatment plan will need to be signed. Sometimes unforeseen things can occur, however you will be informed immediately.

PAYMENT OPTIONS:

- Cash
- Credit Cards: Visa, Mastercard, Amex, Discover
- Checks ($50 fee on any Returned Checks)
- Care Credit/HSA Card/More Healthcare Credit Card/Denefits
- Care Credit, Terms are set by the office, and can be subject to change:
    - 6 Month Interest Free for charges over $500
    - 12 Month Interest Free for charges over $1000
    - You may use the interest option on any charge
- **All Past Due Balances on account will be collected at Check In**
- Patient co-pays or patient payments will be collected at Check In
- Orthodontic Patients: Auto payments in office Each Month as specified in your orthodontic contract.

BALANCES:

- Smiles By Hazen, PA files all claims the day the service is rendered. However, if the insurance does not pay on your account within 60 Days, the patient is responsible for the unpaid balance. If the insurance pays after you have, you will be refunded the difference if there are no balances on account.
- Patient's always have the right to follow up on unpaid dental claims with their insurance company at any time, and usually are able to have more effective communication with the carrier. We strongly encourage the patient to contact the dental carrier with any concerns pertaining to the dental plan.
- Once the claim has been paid, you will be mailed a statement if there is a balance. After 90 days the account may be placed for Collections if the balance is unpaid. Patient responsible for collection fees.
- You have the option to provide your Credit Card information to keep on file for any unpaid portion of your dental claim. ****OPTIONAL TO PUT YOUR CREDIT CARD ON FILE****
- Credit Card Type:_____ CC#:_____
  - Expiration Date: _____ CVV:_____ Billing Zip Code:_____
  - Name on Card: _____ Signature:_____
  - If you choose this option, you are authorizing Smiles By Hazen, PA to charge any unpaid balance on the account to your credit card.
- Please keep the office Updated with any changes in your Dental Insurance Coverage as soon as you become aware. Provide the office with a copy of your new insurance card as soon as you receive it so that we can quickly update your account.
- **When using Care Credit as a form of payment, you MUST be on the account as an authorized user, and present with 2 Forms of Identification, as requested by Care Credit.** If you do not have 2 Forms of Payment, we will not be able to process the payment. If the account belongs to a spouse, the spouse MUST BE PRESENT with 2 forms of ID. We encourage the card holder to contact Care Credit to add you as an authorized user if you wish to use the card without the card holder present.
- Yearly you will be asked to provide a copy of your Driver's License along with Your Insurance Card so that we keep our records up to date. Please have this information available.
- If you have a change in address, phone number, email address, name or insurance, you are asked to provide us the information immediately. Dental claims may be denied if submitted with outdated information.
- **Some Dental Plans will apply your Deductible to the first visit.** Most deductibles range from $25-$150.
- If you need to change a scheduled dental appointment, Dr. Hazen asks that you provide the office with 2 Business Days notice. **A fee of $35 for each missed appointment will be applied to your account otherwise.**

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Printed Name: _____ Date:_____

Signature of Patient/Guardian: _____

**Form Date: January 2018/Policies are subject to change*

SMILES BY HAZEN

Ryanne Hazen Gilliland, DDS

19001 US Hwy 441 Mount Dora, FL 32757

Office: 352.383.9406 Fax: 352.600.3370

www.Teethinaday.com

Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____