Absolute Smiles Dentistry
T.S. Kimball, III, D.D.S.

2065 Airway Ave.
Suite B
Kingman, AZ 86409
Phone (928) 718-0002
Fax (928) 718-0007

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT OR WRITE LEGIBLY

PERSONAL INFORMATION:

Name:_____ SS#:_____

Address:_____
Street City State Zip

Phone: Home_____ Work_____ Cell_____

Best time to reach you at each number to confirm: Home _____ Work _____ Cell _____

Birthday: _____ Sex: M ___ F ___ Email address: _____

Marital Status: _____ Spouse name: _____

Employer & Occupation: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship: _____ SS#: _____

Address: _____
Street City State Zip

Phone: Home _____ Work_____ Cell_____

DENTAL INSURANCE INFORMATION:

Insurance Company: _____

Address:_____
Street City State Zip

Employee Name: _____ Date of Birth _____ SS# _____

Employer Name: _____ Group # _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement. By signing below, I authorize treatment for:

_____.

SIGNATURE: _____ DATE: _____

REFERRED BY: _____or

Phone Book ___ Sign ____ Advertisement ____ Facebook ____ Google _____

Financial Policy for

Absolute Smiles Dentistry

DEAR PATIENT: We will bill your insurance company as a courtesy to you. We will wait 60 days for the insurance company to remit payment. If it is not paid within this time, the total bill becomes due and payable in full by the person responsible for payment of this account. We suggest you work closely with your insurance company to expedite payment. It is your responsibility to provide them with information if requested. *Please forward any information they may request.*

Please initial after reading _____

AGREEMENT FOR PAYMENTS AND RECORDDS RELEASE

ALL PATIENTS

I acknowledge full financial responsibility for medical services rendered; and I agree to pay in full at the time of service or to make **prior** arrangements for payment.

If my account is sent to **collections**, I acknowledge responsibility for associated collection expenses. A 50% collection fee will be added to any balance turned over to a collection agency.

BROKEN OR MISSED APPOINTMENTS: There will be a $25 charge for all appointments canceled or broken without a 24-hour notice. There will be a $25 charge for all returned checks. We work closely with the Mohave County's Sheriffs Office for collection of unpaid, returned checks. After 60 days, interest will accrue on unpaid balances.

I authorize you to release my medical records to my doctor and to the doctor who referred me, and to release any information to my insurance company necessary for processing the claim. I also authorize you to request a copy of summary of my medical records from other care providers.

I request that the payment of benefits be made on my behalf to Absolute Smiles Dentistry, for any service furnished me by their providers.

SIGNATURE_____ DATE_____

PRINTED NAME_____

How will you be paying your portion of today's visit?
CASH__ CHECK__ CREDIT CARD__

Insurance information: See first page.

Please present your insurance card and your driver's license at the front desk.

THANK YOU! We appreciate your patronage and your patience. Please make sure you have completed all questions on the other pages included. This will enable this office to file your insurance claims with correct information. Incorrect information will result in a denied claim. It will then become your responsibility to re-file with your insurance company and your responsibility to pay immediately.

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Effective Date: April 14, 2003. This notice describes how personal health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

We request patient confidentiality and only release personal health information about you in accordance with the state and federal law. This notice describes out policies related to the use of the records of your care generated by Absolute Smiles Dentistry.

Privacy Contact: If you have any questions about this policy or your rights, contact the Privacy Coordinator at (928) 718-0002

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond Absolute Smiles Dentistry. This includes;

Treatment: With your permission, we may use or discuss personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside Absolute Smiles Dentistry that we are consulting with or referring you to.

Payment: Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance for prior approval of planned treatment or for billing purposes.

Healthcare Options: We may use information about you to coordinate our business activities. This may include setting up for your appointments, reviewing your care, and training staff.

Information Disclosed Without Your Consent: Under state and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.

Follow up appointment/care: We will be contacting you to remind you of future appointments or information about treatment alternatives or other health related benefits and services may be of interest to you.

As Required by Law: This would include situations where we have a subpoena, court order, or are mandated to provide health information, such as communicated disease or suspected abuse and neglect, including child abuse, elder abuse or institutional abuse.

Government Requirements: We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested, with the Department of Health and Human Services to determine our compliance with Federal laws related to health care.

Criminal Activity or Danger to Others: If a crime is committed on our premises or against our personnel, we may share information with law enforcement officials to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT REQUESTS — You have the following rights under state and federal law

Copy of records: You may consent to inspect the personal health record Absolute Smiles Dentistry has generated about you. We may charge you a reasonable fee for copying and mailing your record. ALL ACCOUNT BALANCES MUST BE PAID IN FULL___ initials

Release of records: You may consent in writing to release your records to others for any purpose you choose. This could include an attorney, employer, or others who you wish to have knowledge of your care. You may receive this consent at any time, but only to the extent no action has been taken in reliance on your prior authorizations. ALL ACCOUNT BALANCES MUST BE PAID IN FULL ____ initials

Restriction of Record: You may ask us to use or disclose part of your personal health information. This request must be in writing. Absolute Smiles Dentistry is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Practice Manager who will consult with the staff involved in your care to determine if the request can be granted.

Contacting YOU: You may request that we sent information to another address by the alternative means. We will honor such a request as long as it is reasonable and we are assured it is correct. We have the right to verify that the payment information you are providing is correct. Due to agency policy, we are not able to provide information by email.

Amending Record: If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this, contact the Practice Manager and as for the Request Amend Health Information Form. In certain cases, we may deny your request, if we deny your request for an amendment, you have a right to file a statement stating that you disagree with us.

Accounting for Disclosure: You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment of health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release to receive information regarding discloses made for a specific time period, no longer than six years, and after April 14, 2003, please submit your request in writing to our Privacy Coordinator. WE will notify you of the cost involved in preparing this list.

Questions and Complaints: If you have any questions or complaints you may contact our Privacy Coordinator in writing at our office for further information. We will not retaliate against you for filing a complaint.

Changes in Policy: Absolute Smiles Dentistry reserves the right to change its Privacy Policy based on the needs of Absolute Smiles Dentistry and changes in state and federal law.

_____patient signature _____date

Patient Name_____

DENTAL HISTORY

Reason for visit:_____

Have you in the past had a bad experience with a dentist? YES_____ NO_____

If yes, please explain_____

Does the thought of going to the dentist make you nervous? YES_____ NO_____ A LITTLE_____

Circle any of the following that apply to you:

Bleeding gums	**Chew on one side of mouth**	**Pain while brushing**
Blister on lips/mouth	**Popping or clicking jaw**	**Orthodontic treatment**
Lip/Cheek biting	**Food collection between teeth**	**Pain around ear**
Mouth breathing	**Foreign objects in mouth (piercings)**	**Periodontal treatment**
Burning sensation on tongue	**Gums swollen or tender**	**Sensitivity to heat/cold**
Bad breath	**Jaw pain or tenderness**	**Sensitivity to sweets**
Dry mouth	**Loose teeth**	**Sensitivity to biting**
Grinding teeth	**Broken teeth or fillings**	**Mouth sores/growths**

How often do you brush? _____

How often do you floss? _____

Former Dentist_____Phone_____

City/State_____

Date of last dental visit_____ Date of last x-ray_____

Please turn page over and complete the other side

MEDICAL HISTORY:

Family Physician: _____Phone: _____

1. Have you been a patient in the hospital during the past 2 years? YES___NO___
2. Have you been under the care of a medical doctor during the past 2 years? YES___NO___
3. Have you ever had any excessive bleeding requiring special treatment? YES___NO___

Circle any of the following conditions that you have had or have at present:

Heart failure	**Bruise easily**	**AIDS**
Heart disease	**Emphysema**	**Hepatitis A (infectious)**
Heart valve problem	**Cough**	**Hepatitis B (serum)**
Angina pectoris	**Tuberculosis**	**Hepatitis C**
Liver disease	**High blood pressure**	**Asthma**
Yellow jaundice	**Heart murmur**	**Hay fever**
Blood transfusion	**Hemophilia**	**Drug addiction or use**
Rheumatic fever	**Sinus trouble**	**Venereal disease**
Congenital heart disease	**Allergies or hives**	**Cold sores**
Artificial heart valve	**Diabetes Type I/ Type II**	**Fainting or dizzy spells**
Heart pacemaker	**Epilepsy or seizures**	**Pain in jaw joints**
Heart surgery	**Nervousness**	**Psychiatric treatment**
Artificial joint	**Cancer**	**Thyroid disease Hypo/Hyper**
Anemia	**Chemotherapy**	**Sickle cell anemia**
Stroke	**Arthritis**	**Sleep apnea/ Snoring**
Kidney trouble	**Rheumatism**	**Glaucoma**
Ulcers	**Take steroid meds**	**Other_____**

4. Do you smoke or use tobacco products? YES___NO___ if so, AMOUNT:_____
5. Do you have any disease, condition or problem not listed? YES___NO___ if so, WHAT_____
6. Women only: Are you pregnant now? YES___ NO___ Breastfeeding? YES___NO___

CURRENT MEDICATIONS

_____
_____
_____

ALLERGIES: (CIRCLE THOSE THAT APPLY)
Penicillin, Latex, Metal,
Local Anesthetics, Codiene
Other:_____

To the best of my knowledge, all the proceeding answers are true and correct. If there is any change in my health or a medical change, I will inform the doctor at the next appointment.

_____ _____
Signature of patient, parent or guardian **Date**