East Side Smiles Intake Forms

Welcome to our practice! Please complete these forms as accurately as possible. It is important for us to have this information in order for us to bride you with the best possible care for you and/or your child. The information you share with us is strictly confidential.

PERSONAL INFORMATION

- **Patient's Full Name:** _____
- **Date of Birth**: _____/_____/_____
- **Mailing Address** (PLEASE INCLUDE APT #, CITY AND ZIP CODE**):**
  _____
- **Cell Phone Number:** (_____) _____- _____
- **Other Phone Number**: (_____) _____- _____
- **EMAIL Address**: _____@_____.com
- **Employer:** _____
- **Occupation**: _____

In the event of an emergency, who do you want us to contact?

Name: _____ Phone Number: _____ Relationship: _____

INSURANCE INFORMATION

Insurance Company Name: _____

Member/Enrollee ID Number/SSN: _____

Name of Primary Subscriber: _____

Date of Birth of Primary Subscriber: _____/_____/_____

Relationship to Patient (if other than self): _____

East Side Smiles Intake Forms

MEDICAL HISTORY

(Previous) Dentist Name:_____ **Office Phone Number**: _____

Date of Last Exam: _____ Last Cleaning:_____ Last X-Ray:_____

Had Previous Orthodontic Care? _____ REASON FOR VISIT TODAY? _____

Please check YES or NO to indicate if the patient has, has had, or has been diagnosed with any of the following:

COVID-19 Yes___ No___ **Mitral Valve Prolapse** Yes___ No___

Covid 19 Vaccine Yes____ No___ **Shingles** Yes___ No___ **Sinus Trouble** Yes___ No___

AIDS/HIV Yes___ No___ **Dizziness/Fainting** Yes___ No___ **Ulcer** Yes___ No___

Hepatitis Yes___ No___ **Nervous Disorder** Yes___ No___ **Seizures** Yes___ No___

If yes, circle…(A,B,C,D,E) **Heart Condition** Yes___ No___ **Cancer** Yes___ No___

High/Low Blood Pressure Yes___ No___ **Kidney Disorder** Yes___ No___ **Anemia** Yes___No ___

Asthma Yes___ No___ **Bone Disorder** Yes___ No___ **Tobacco Smoker** Yes___ No___

Liver Disorder Yes___ No___ **Alcohol/Drug Abuse** Yes___ No___

Psychiatric Care Yes___ No___ **Heart Murmur** Yes___ No___

Latex Allergy Yes___ No___ **Diabetes** Yes___ No___ **Trauma to Face/Jaw** Yes___ No___

PHARMACY NAME, PHONE NUMBER & ADDRESS:

_____

ALLERGIES: _____

Other Medical Condition not listed above: _____

Medications Currently taking:_____

Have you ever had ANY replacement (ie: hip, knee…) surgery that would require you to be pre-medicated with antibiotic prior to receiving dental treatment? _____

Female Patients:

Are you on any type of prescribed birth control, if so, please specify: _____

Are you/any chance you could be currently pregnant and or nursing?

_____

East Side Smiles Intake Forms

1) **WORK TO BE DONE TODAY**: I understand that I am having the following work done : __Exam, __X-Rays, __Prophylaxis (cleaning) __Fillings __Crown(s) __Post & Core __Denture(s)/Bridge(s) __Root Canal(s),__Other:_____ _____**PATIENT /GUARDIAN INITIALS**

2) **DRUGS/MEDICATIONS**: I understand that antibiotics, analgesics & other medications can cause allergic reactions such as redness, swelling, pain, itching vomiting and/or anaphylactic shock.

_____**PATIENT/GUARDIAN INITIALS**

3) **CHANGES IN TREATMENT PLAN(S):** I understand that during my procedure it may be necessary to change or add procedure(s) because of conditions found while working on teeth that were NOT discovered during the initial evaluation. I give Dr. Igor Korotun permission to make any/all necessary changes.

_____**PATIENT/GUARDIAN INITIALS**

4) **TEETH REMOVAL:** I understand that removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand the risks of having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last indefinitely. I understand that I may need further treatment by a specialist should complications arise during or following treatment, the cost of which is my responsibility. I authorize Dr. Igor Korotun to extract teeth #_____.

_____**PATIENT/GUARDIAN INITIALS**

5) **ENDODONTIC TREATMENT:** I realize there is no guarantee that root canal therapy will save my tooth and that complications can occur from treatment, and that occasionally the filling material may extend through the tooth which does not necessarily effect the success of treatment. I understand that endodontic files are very fine instruments & stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts performed by Dr. Igor Korotun to save it.

_____**PATIENT/GUARDIAN INITIALS**

6) **FILLINGS/INLAYS/ONLAYS:** I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. _____**PATIENT/GUARDIAN INITIALS**

7) **CROWNS/BRIDGES:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily & that I must be careful to ensure that they are kept on until the permanent crowns are delivered. It is MY responsibility to return for permanent cementation within 1 days from tooth preparation. Excessive delay may result in tooth movement and this may necessitate a remake of the crown or bridge. I understand that there may be additional charges for remakes.

_____**PATIENT/GUARDIAN INITIALS**

8) **DENTURES:** I understand that the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures may be painful. Imeediate dentures may require a considerable amount of adjustments and several relines. I understand that it is my responsibility to return for the delivery of dentures. I understand that failure to keep my appointment may result in poorly fitted denture. If a remake is required due to my delay of 30 days, there will be additional charges.

_____**PATIENT/GUARDIAN INITIALS**

Patient/Guardian Signature: _____ Today's Date_____

East Side Smiles Intake Forms

OFFICE POLICIES

1) **Lateness**: We have a strict 15 minutes lateness policy. If you are more than 15 minutes late we will have to reschedule it if it interferes with the following patient's appointment.
2) **No Show Policy**: If you miss an appointment without a 24 hour notification, you will be **subject to a $50.00 charge**. This is NOT payable by your insurance and is the sole responsibility of the patient.
3) **Contact Information**: It is the patient's responsibility to notify the office of his/her name, address or contact information change.
4) **Insurance**: As a courtesy to our patients we will verify your insurance coverage at the time of your appointment, VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. You, as the patient, are responsible to know your deductible, maximum and co-payments. We ask that you clarify these questions with your insurance company prior to your visit.
5) **ALL SERVICES MUST BE PAID AT THE TIME OF VISIT**.
6) Any balance overdue by 90 days, or after the final dental bill has been sent to the patient, will be submitted to collections.
7) Our office will not enter into a dispute with your insurance company for dental claims if the dental was due to your negligence (ie: policy termination, premium not paid, etc...)
8) We cannot guarantee that your insurance company will pay. We will make every attempt at the beginning of your dental care to verify your policy and what is and is not covered. In the event that you are denied because your insurance has been terminated or your annual maximum has been met, the patient is responsible for the unpaid balance.

I have read the above information and fully understand my responsibilities as a patient of East Side Smiles dental practice.

Patient/Guardian Signature: _____ Today's Date: _____

East Side Smiles Intake Forms

HIPAA Authorization

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.

We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care services; or getting copies of your health information from another professional that you may have seen before us. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this notice.

East Side Smiles Intake Forms

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or e-mail shown at the end of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new Notice in our office, have copies available in our office, and post it on our website.

Complaints

If you think we have not properly respected the privacy of your heath information, you are free to complain to us or the U.S Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

I acknowledge that I have read, received, and understood East Side Smiles' Notice of Privacy Practices.

Patient Name _____

Signature _____ **Date** _____

East Side Smiles Intake Forms