SMILEY FAMILY DENTISTRY

Welcome to Smiley Family Dentistry!

Thank you for choosing our office to meet your dental health care needs. It is our goal to provide you and your family with the highest quality of dental care in a friendly and relaxed environment. In order to keep our standard of care to a level which best serves your dental needs, we ask you to please observe the following guidelines.

Payment Policy

Payment in full is expected at the time of service. The charges for the services we render reflect the high level of training of the providers in our practice and the high level of care the patient receives. Our office will electronically submit an insurance claim with any supporting documentation required on the patient's behalf. I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance. The patient is also expected to be aware of the provisions of their own insurance coverage.

We understand that it is not always possible to pay in full at the time of service. Our office will extend a 90 day payment option for our patients with more extensive treatment plans. 12 month, no interest financing through Care Credit is also available. Please see our accounts manager, for more details.

If your account becomes past due and there is not a valid reason for payment delay, appropriate action will be taken to recover the amount due within 90 days of the initial billing. Any cost incurred by our office to obtain payment will also be the responsibility of the patient.

Cancellation Policy

There are many times when other patients require urgent or emergency treatment and must be seen as soon as possible. When you provide our office with advanced notice of a need to cancel a scheduled appointment, this time can then in turn be allocated to patients in urgent need of treatment. In this way the office can best serve the needs of each of our patients.

We request that you provide us with at least 48 hours notice if you need to reschedule an appointment. Continued failure to keep scheduled appointments will result in our not being able to take responsibility for your oral health, and your dismissal as a patient in our practice.

SMILEY FAMILY DENTISTRY

We understand that flat tires, sick children and family emergencies do happen and we do make allowances for such events. If you are not able to provide us with a 48 hour notice, please call and advise us of any special circumstances that caused you to miss your scheduled appointment. We appreciate your understanding of our policies and we look forward to helping you achieve good dental health.

______________________________ ___/___/___

Authorizing Signature **Date**

Christopher J. Smiley, D.D.S.
Stephanie M. Benton, D.D.S.

3299 Clear Vista Ct., N.E. | Suite A | Grand Rapids, Michigan 49525 | 616 361 0654 | www.smileydds.com

PATIENT REGISTRATION

PATIENT'S NAME ______________________________
LAST FIRST INITIAL

HOW DO YOU WISH TO BE ADDRESSED ______________________________

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

RESIDENCE: STREET ______________ STATE ________ ZIP ________

CITY ______________________________

BUSINESS ADDRESS ______________________________

TELEPHONE: RESIDENCE ______________ BUSINESS ______________

CELL ____________ APPOINTMENT CONFIRMATION NUMBER ____________

EMAIL ______________________________

PATIENT EMPLOYED BY ______________ HOW LONG HELD ________

PRESENT POSITION ______________________________

SPOUSE NAME ______________________________

SPOUSE EMPLOYED BY ______________ HOW LONG HELD ________

PRESENT POSITION ______________________________

WHO WILL PAY THIS ACCOUNT ______________________________

BILLING ADDRESS (IF DIFFERENT) ______________________________

DATE ______________ DATE OF BIRTH ______________

OTHER FAMILY MEMBERS IN THIS PRACTICE ______________________________

____

WHOM MAY WE THANK FOR THIS REFERRAL ______________________________

____

PATIENT'S SOCIAL SECURITY NUMBER ______________________________

SPOUSE'S SOCIAL SECURITY NUMBER ______________________________

SOMEONE TO NOTIFY
IN CASE OF EMERGENCY
NOT LIVING WITH YOU ______________________________

____

PAYMENT POLICY

Patients are asked to settle their accounts at the time of service. We accept Master Card, Visa, and Discover, and for more extensive treatment we are willing to extend payment plans.

Our office will complete and submit most types of dental insurance claim forms. Please remember that insurance is a method of reimbursing the patient for dental expenses. Because insurance is a contract between the patient and their employer or insurance company, the responsibility for payment of the account is your direct obligation.

CANCELLATION POLICY

If you have to reschedule or cancel an appointment, please give us at least 48 hours notice. Patients who cancel without informing us beforehand may be billed for their missed appointment and repeated cancellations may result in a patient not being rescheduled.

WE ARE COMMITTED TO PROVIDING YOU WITH QUALITY DENTAL CARE. WHAT ARE YOUR EXPECTATIONS FOR YOU AND YOUR FAMILY'S DENTAL CARE?

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MEDICAL DENTAL HISTORY

PATIENT'S NAME ____

LAST FIRST INITIAL DATE OF BIRTH

MEDICAL HISTORY:

WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAM? ______________

PHYSICIAN'S NAME ______________

ADDRESS ______________

ARE YOU UNDER A PHYSICIAN'S CARE? ______________

PLEASE LIST MEDICATIONS YOU ARE TAKING ______________

____

____

BLOOD PRESSURE:
☐ HIGH ☐ LOW ☐ NORMAL S ________ /D ________

DO YOU SMOKE? ______________

DO YOU CONSUME ALCOHOLIC BEVERAGES? ______________

HAVE YOU TAKEN MEDICATIONS FOR WEIGHT LOSS? ______________

HAVE YOU TAKEN MEDICATIONS FOR OSTEOPOROSIS? ______________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE INDICATE WITH CHECK MARK.

- ☐ ANY HEART PROBLEMS
- ☐ CIRCULATORY PROBLEMS
- ☐ RADIATION TREATMENTS
- ☐ EXCESSIVE BLEEDING
- ☐ HIV
- ☐ ALLERGIES TO ANESTHETICS
- ☐ ALLERGIES TO LATEX
- ☐ ALLERGIES TO MEDICINES OR DRUGS ______________
- ☐ ALLERGIES TO PENICILLIN
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINT
- ☐ ASTHMA
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ HEART VALVE IMPLANT
- ☐ HEPATITIS
- ☐ HERPES
- ☐ MALIGNANCIES
- ☐ MEASLES
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ ULCER

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING OPERATIONS, OR ANY OTHER MEDICAL OR DENTAL INFORMATION THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT.

____

____

DENTAL HISTORY:

PURPOSE OF INITIAL VISIT ______________

____

ARE YOU AWARE OF A PROBLEM? ______________

HOW LONG SINCE YOUR LAST DENTAL VISIT? ______________

WHAT WAS DONE AT THAT TIME? ______________

____

PREVIOUS DENTIST ______________

ARE YOU CURRENTLY BEING TREATED BY AN ORTHODONTIST (IF SO WHO) OR HAVE A HISTORY OF ORTHODONTIC TREATMENT? ______________

____

HAVE YOU BEEN DIAGNOSED WITH PERIODONTAL DISEASE? ______________

HAVE YOU MADE REGULAR VISITS? ______________

WERE DENTAL X-RAYS RECENTLY TAKEN? ______________

HAVE YOU LOST ANY TEETH? ________ WHY? ______________

WERE THERE ANY COMPLICATIONS AFTER TOOTH REMOVAL? ______________

HAVE THEY BEEN REPLACED? ________ WHEN? ______________

HOW? ______________

DO YOU CLENCH OR GRIND YOUR TEETH? ______________

DOES YOUR JAW CLICK OR POP? ______________

HAVE YOU EXPERIENCED ANY PAIN OR SORENESS IN THE MUSCLES OF YOUR FACE OR AROUND THE EAR? ______________

DOES FOOD GET CAUGHT BETWEEN YOUR TEETH? ______________

ARE ANY TEETH SENSITIVE TO: ☐ HOT ☐ COLD ☐ SWEETS ☐ PRESSURE

HOW OFTEN DO YOU BRUSH YOUR TEETH? ________ WHEN? ________

DO YOUR GUMS BLEED OR HURT WHEN BRUSHING? ______________

DO YOU USE DENTAL FLOSS? ________ HOW OFTEN? ________

DO YOU TAKE FLUORIDE IN ANY FORM? ______________

HAS ANYBODY TOLD YOU YOUR BREATH IS OFFENSIVE? ______________

HOW DO YOU FEEL ABOUT YOUR TEETH IN GENERAL? ______________

____

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? ______________

HAVE YOU HAD ANY UNPLEASANT DENTAL EXPERIENCES OR ANYTHING ABOUT DENTISTRY THAT YOU STRONGLY DISLIKE? ______________

____

DO YOU HAVE ANY QUESTIONS OR CONCERNS? ______________

____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

____

PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF A MINOR) DATE

DENTAL INSURANCE AUTHORIZATION INFORMATION

*Please complete the following so we may process any and all dental insurance

Primary Policy Holder Dental Insurance:

Name: ____ DOB: ___/___/____

SS#: ________-_______-________ Phone: _____-____-______

Address: _________________________________ City: ___________State: _____ Zip:______

Employer: ____ Phone: ____-_____-______

Address: _______________________________ City: ___________State: _____ Zip:________

Insurance provider: _______________________________________ Phone:____-____-_____

Address: _______________________________ City: ___________State: _____ Zip:________

I authorize the release of any information relating to this claim and authorize the payment directly to the Dentist of the insurance benefits otherwise payable to me.

____

Signature (parent or guardian if a minor) Date

Secondary Policy Holder Dental Insurance:

Name: ____ DOB: ___/___/____

SS#: ________-_______-________ Phone: _____-____-______

Address: _________________________________ City: ___________State: _____ Zip:______

Employer: ____ Phone: ____-_____-______

Address: _______________________________ City: ___________State: _____ Zip:________

Insurance provider: _______________________________________ Phone:____-____-_____

Address: _______________________________ City: ___________State: _____ Zip:________

I authorize the release of any information relating to this claim and authorize the payment directly to the Dentist of the insurance benefits otherwise payable to me.

____

Signature (parent or guardian if a minor) Date

***If you have a 3rd or 4th dental insurance policy, please let us know, thank you

Christopher J. Smiley, D.D.S.
Stephanie M. Benton, D.D.S.

3299 Clear Vista Ct., N.E. | Suite A | Grand Rapids, Michigan 49525 | 616 361 0654 | www.smileydds.com

PEDIATRIC PATIENT REGISTRATION

CHILD'S NAME ____
LAST FIRST INITIAL

NICKNAME ____

RESIDENCE STREET ____

CITY ____________________ STATE __________ ZIP __________

TELEPHONE ____

APPOINTMENT CONFIRMATION NUMBER ______________________________

PARENT'S EMAIL ADDRESS ______________________________________

CHILD'S SOCIAL SECURITY NUMBER ______________________________

AGE ____________________ WEIGHT ____________________

☐ MALE ☐ FEMALE

SCHOOL OR DAYCARE NAME ______________________________________

NAME OF SIBLINGS ____

NAME OF PET/FRIEND ____

DATE ____________________ DATE OF BIRTH ____________________

SPORTS OR ACTIVITIES ____

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________

OTHER FAMILY MEMBERS IN THIS PRACTICE ______________________________

EMERGENCY CONTACT ____

____

____

PAYMENT POLICY

Patients are asked to settle their accounts at the time of service. We accept Master Card, Visa and Discover, and for more extensive treatment we are willing to extend payment plans.

Our office will complete and submit most types of dental insurance claim forms. Please remember that insurance is a method of reimbursing the patient for dental expenses. Because insurance is a contract between the patient and their employer or insurance company, the responsibility for payment of the account is your direct obligation.

CANCELLATION POLICY

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WE ARE COMMITTED TO PROVIDING YOU WITH QUALITY CARE. WHAT ARE YOUR EXPECTATIONS FOR YOU AND YOUR FAMILY'S DENTAL CARE?

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____

MEDICAL DENTAL HISTORY

PATIENT'S NAME ______________________________
LAST FIRST INITIAL DATE OF BIRTH

MEDICAL HISTORY:

CHILD'S PEDIATRICIAN ______________________________

ADDRESS ______________________________

PHONE ______________________________

DATE OF LAST EXAM ______________________________

ANY PRESENT ILLNESS? ______________________________

CURRENT MEDICATIONS TAKEN______________________________

ALLERGIES OR ADVERSE REACTIONS TO ANY MEDICATIONS? ____________

____

____

____

____

ALLERGY TO LATEX PRODUCTS?______________________________

ANY OTHER ALLERGIES?______________________________

HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

- ☐ ADD/ADHD
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ AUTISM
- ☐ BLEEDING DISORDER
- ☐ COLD/CANKER SORES
- ☐ DIABETES
- ☐ EMOTIONAL PROBLEMS
- ☐ EPILEPSY/CONVULSIONS
- ☐ FAINTING OR DIZZINESS
- ☐ HEARING PROBLEM
- ☐ HEART PROBLEM
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIV/AIDS
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MENTAL DISORDER
- ☐ RHEUMATIC FEVER
- ☐ SLEEP APNEA
- ☐ TUBERCULOSIS
- ☐ TUMORS/CANCER
- ☐ SPECIAL NEEDS/OTHER:

____

____

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE OR OTHER PROBLEMS NOT LISTED:

____

____

DENTAL HISTORY:

PURPOSE OF TODAY'S VISIT ______________________________

____

PREVIOUS DENTIST ______________________________

DATE OF LAST DENTAL VISIT/LAST XRAY'S______________________________

HAS YOUR CHILD SEEN THE ORTHODONTIST? ______________________________

NAME OF ORTHODONTIST______________________________

LAST ORTHODONTIC VISIT ______________________________

HAS YOUR CHILD HAD DIFFICULTY WITH PREVIOUS DENTAL VISITS?________

____

HOW OFTEN DOES YOUR CHILD BRUSH?______________________________

HOW OFTEN DOES YOUR CHILD FLOSS? ______________________________

DOES YOUR CHILD:

TAKE FLUORIDE SUPPLEMENTS?______________________________

USE A PACIFIER?______________________________

SUCK THUMB OR FINGER?______________________________

SUCK OR BITE LIP?______________________________

BITE OR CHEW NAILS?______________________________

GRIND TEETH?______________________________

CLENCH JAWS?______________________________

GAG EASILY?______________________________

HAVE A HISTORY OF INJURY TO MOUTH OR TEETH?____________________

SENSITIVE OR PAINFUL TEETH?______________________________

DRINK CITY OR WELL WATER?______________________________

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

____

PARENT'S SIGNATURE DATE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

How We May Use And Disclose Health Information About You

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and

coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by

sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Kori DeHaan
Telephone: (616) 361-0654
Fax: (616) 361-9823
Address: 3299 Clear Vista Ct NE, Grand Rapids, Michigan, 49525
E-mail: kori@smileydds.com