A Summer Smile
MODERN DENTISTRY IN AUSTIN

Welcome to our practice
A place you can feel at home and be treated like family

Today's Date: _____ E-mail Address: _____

Name: _____ Name I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ____/____/____ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Home Phone #: (___) _____ Cell #: (___) _____ Work Phone #: (___) _____ Ext: ____ Driver's License #: _____

Whom may we thank for referring you? _____ Did you hear of us from? ❑ Web Site ❑ Flyer/Mail

❑ Go Local ❑ Community Impact ❑ Insurance List ❑ Auskins ❑ Driveby ❑ Other: _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Spouse or Emergency Contact Information

His / Her Name: _____ Birthdate: ____/____/____ Relationship: _____

Home Phone #: (_____) _____ Work Phone #: (_____) _____ Ext: _____

Insurance Information

Insurance Co. Name: _____ Phone #: (_____) _____ Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Insured's Social Security #: _____

Insured's Address: _____
Street City State Zip

Insured's Birthdate: ____/____/____ Relationship: _____ Insured's Employer: _____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? ❑ Yes ❑ No

Previous/ Present Dentist: _____ Last Vist Date: _____
(Please Circle)

Why did you leave your last dentist? _____

Dental History (continued)

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

If No, what would you like to change: *(circle those that apply)*

Length, Shade, Spaces, Crowding, Other: _____

_____

Have you ever had any serious complications with prior dental treatment? ☐ Yes ☐ No

If yes, what? _____

Have you had any head, neck or jaw injuries? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Have you ever experienced any of the following problems in your jaw?

- Clicking? ☐ Yes ☐ No
- Pain (joint, ear, side of face)? ☐ Yes ☐ No
- Difficulty in opening or closing? ☐ Yes ☐ No
- Difficulty in chewing? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Have you had any orthodontic work? ☐ Yes ☐ No

Have you ever whitened your teeth? ☐ Yes ☐ No

If yes, what type of product? _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Redux or Pondimin? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: _____ Are you nursing? ☐ Yes ☐ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No If yes, please list each one: _____

_____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered. As a courtesy, we will file your dental insurance as an out of network provider, so you may receive a reimbursement. I have received a copy of this office's Notice of Privacy Practices.

_____
Signature Date

office use only office use only office use only office use only **Medical History Update** *office use only office use only office use only office use only*

I have read my medical history dated _____ and confirmed that is states past and present medical conditions _____
Signature Date

I have read my medical history dated _____ and confirmed that is states past and present medical conditions _____
Signature Date

I have read my medical history dated _____ and confirmed that is states past and present medical conditions _____
Signature Date

A Summer Smile

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out ***treatment, payment activities, and healthcare operations only.***

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Julie Cutler**

Telephone: **(512) 382-1969** Fax: **(512) 215-2038**

E-mail: **julie@youraustintxdentist.com**

Address: **8656 Hwy. 71 West, Building D - Suite 100 Austin, TX 78735**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have received and read a copy of this office's Notice of Privacy Practices. I have had full opportunity to consider the contents of your Notice of Privacy Practices and this Consent for Use and Disclosure of Health Information. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out **treatment, payment activities and healthcare operations only.**

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

A Summer Smile
Summer Rydel, D.D.S.
8656 Hwy. 71 West, Building D - Suite 100
Austin, TX 78735
Tel: (512) 382-1969 • Fax: (512) 215-2038

Financial Options & Your Insurance Plan

The staff at A Summer Smile is proud to deliver the finest and most comprehensive health care available today! In addition, we are also dedicated to making top quality care as cost effective as possible.

Financial Options

A Summer Smile requests payment or assignment of payment at the time of service. We accept MasterCard, VISA, Discover, Care Credit, and assignment of insurance benefits. In some circumstances we do offer extended financial options, BUT these arrangements must be made PRIOR to treatment.

Do you accept my insurance? How much will they pay?

The staff at A Summer Smile is pleased that you have insurance benefits to help with the cost of your dental care and would like to help you obtain the maximum use of these benefits. Please read the information on onr insurance claims process so that we can work together to ensure this benefit.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to go into a contractual agreement). This means that we work with literally thousands of companies. Although we can look at companies' past payment history, their policies do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know from your insurance company your insurance benefit for specific treatment, we will be happy to file a "pre-treatment authorization" with them prior to treatment. This does delay treatment and is still not always guaranteed by the insurance company.

I thought I paid my portion but I got a bill, why?

We base the patient portion of your bill on our most current data but there are many factors that can affect this estimate. Insurance companies have hundreds of plans and coverage varies from group to group, even within the same company. Therefore we can ask for general coverage information but they cannot relay to us every particular clause of your policy. Also, there may be a deductible (individual or family) or you may have received treatment in another office prior or in addition to A Summer Smile which will not be calculated into our database. Sometimes you may need to see a specialist for care; this also uses your annual benefits. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they may only notify you.

Insurance did not pay, now what?

We bill your insurance as a courtesy. If insurance does not pay within 60 days, A Summer Smile reserves the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Please note there is a $25.00 fee if an appointment is canceled without a 24 hour notice.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at A Summer Smile.

Signature _____ Date _____