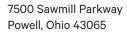


7500 Sawmill Parkway Powell, Ohio 43065 **740.881.2600** 

# **Patient Information**

Patient first name		M.I Patien	t last name
Preferred name			
Patient SSN	Gender		Date of birth
Patient address			
City	State		Zip code
Primary phone(	Home   Cell   Work	Secondary phone	
Email			
I would like to receive correspondence	e by email.		
I am able to accept text messages.			
Emergency contact name			
Relationship to patient		Emergency contact	phone
Responsible party address is same as	above (if different, comple	ete below).	Date of birth
□ \$50 referral bonus   I was ref	erred by an existing patier	nt (patient name must	match our records).
Primary dental insurance info		* Ple	ase provide copy of insurance card *
Relationship to patient			Date of birth
Name of insurance carrier			
Name of employer			
Insured SSN / Member ID			
Group number			







Medical History					
Patient name				Date of birth	1
Although dental personnel primarily treat the area in and are you may be taking, could have an important interrelationship to help us better care for you as our patient.					
Are you under a physician's care now?	O Yes	O No	If yes		
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes		
Have you ever had a serious head or neck injury?	O Yes	O No	If yes		
Are you taking any medications, pills or drugs?	O Yes	O No	If yes		
Do you take, or have you taken, Phen-Fen or Redux?		O No	If yes		
Have you ever taken Fosamax, Boniva, Actonel or any other	O Yes	O No	If yes		
medications containing bisphosphonates?					
Are you on a special diet?	O Yes	O No			
Do you use tobacco?	O Yes	O No			
Do you use controlled substances?	O Yes	O No	If yes		
Women, are you:	come pregna	nt?	☐ Nursing? ☐ ☐	Taking oral contrac	ceptives?
Are you allergic to any of the following?					
Aspirin Penicillin			Codeine		Acrylic
Latex Sulfa Drugs	;		Local Anesthetics	_	
Metal (please specify)			Other (please specify)		
Do you have, or have you had, any of the fo	llowing?				
AIDS/ HIV Positive Diabetes			☐ Hepatitis A		Recent Weight Loss
Alzheimer's Disease Drug Addic	Drug Addiction		☐ Hepatitis B or C		Renal Dialysis
Anaphylaxis Easily Wind	Easily Winded		Herpes		Rheumatic Fever
Anemia Emphysema	а		☐ High Blood Pressure		Rheumatism
Angina Epilepsy or	Seizures		High Cholesterol		Scarlet Fever
Arthritis/ Gout Excessive E	Bleeding		Hives or Rash		Shingles
Artificial Heart Valve Excessive T			☐ Hypoglycemia	П	Sickle Cell Disease
	ells/ Dizzines	S	Irregular Heartbeat		Sinus Trouble
Asthma Frequent Co	-		Kidney Problems	님	Spina Bifida
Blood Disease     Frequent Disease       Blood Transfusion     Frequent H			Leukemia Liver Disease	님	Stomach/ Intestinal Disease
Breathing Problems Genital Her			Low Blood Pressure	H	Stroke Swelling of Limbs
Bruise Easily Glaucoma	pes		Lung Disease	H	Thyroid Disease
Cancer Hay Fever			Mitral Valve Prolapse	ñ	Tonsillitis
Chemotherapy Heart Attac	k/ Failure		Osteoporosis	ñ	Tuberculosis
Chest Pains Heart Murm	nur		Pain in Jaw Joints		Tumors or Growths
Cold Sores/ Fever Blisters Heart Pacel	maker		Parathyroid Disease		Ulcers
Congenital Heart Disorder Heart Troub	ole/ Disease		Psychiatric Care		Venereal Disease
Convulsions Hemophilia			Radiation Treatments		Yellow Jaundice
Cortisone Medicine					
Have you ever had any serious illness not listed?	O Yes	O No	If yes		
Additional comments:					
To the best of my knowledge, the questions on this form he				ing incorrect infor	rmation can be dangerous to my (or the
patient's) health. It is my responsibility to inform the dental of		-		m 1 * 1	
Patient / Responsible party signature				Today's date	

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Neal S. Patel, DDS, CDT



7500 Sawmill Parkway Powell, Ohio 43065 740.881.2600

# Financial Policy

At Infinite Smiles, we want all our guests to be able to comfortably afford dental care. We proudly offer the following financial policy so that our guests have the opportunity to decide which payment option is best for their needs.

#### Insurance

Your insurance is a contract between you, your employer, and your insurance company. Infinite Smiles will gladly work with you to help you get the maximum benefit available to you. Most insurance plans do not cover 100% of the treatment cost. Because of this, we ask that you pay your deductible as well as your ESTIMATED co-pay for the charges on the day services are rendered. We will estimate your coverage as closely as possible, but can make no guarantees as to what your insurance will pay. We understand that dental benefits are important to our guests. After all treatment, we will promptly file and follow up on your dental claims to ensure that you receive the correct maximum benefits. We offer several financial options for your portion of diagnosed treatment so that your care is not compromised due to financial concerns.

## Payment Options

- 1. Cash or Check (There is a \$25 fee for all returned checks)
- 2. MasterCard, Visa, Discover, or American Express
- 3. Lending Club & Care Credit: A convenient line of credit can be arranged, on approval, for your health care needs. Interest-free, and Deferred interest plans are available, as well as long term interest bearing plans.

#### **Appointment Policy**

Because we reserve time specifically for you, it is vital that we receive appropriate notice for cancellations. If you find that you are unable to keep an appointment, please call our office 48 hours in advance. Appointments cancelled within 48 of your appointment and no-show appointments will be charged a fee of \$50 per hour of the missed appointment.

For more extensive procedures, a 20% reservation fee will be collected at the time the appointment is made. This amount collected will be put toward your treatment balance. We understand that circumstances may arise when an appointment may need to be rescheduled. Please make all attempts to do so within 48 hours of your appointment. Due to the expenses we acquire in preparing for larger cases, the 20% cannot be returned if the appointment has to be cancelled and not rescheduled.

## Acknowledgement of Financial Responsibility

I have read all of the above and understand that payment is due at the time of service unless prior arrangements have been made. I understand that my insurance may cover a portion of the treatment; however, I am ultimately responsible for any balance on my account for services rendered. I also understand there is a 48 hour cancellation policy for all appointments and I will be charged a cancellation fee for all appointments cancelled within 48 hours of my scheduled appointment time.

Patient full name	Today's date
Patient / Responsible party signature	

Neal S. Patel, DDS, CDT Expertise Comfort Luxury Innovation



7500 Sawmill Parkway Powell, Ohio 43065

740.881.2600

#### Notice of Privacy Practices

Purpose - This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Infinite Smiles | Dr. Neal Patel, DDS, Inc.

#### **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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

#### Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 11, 2008, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

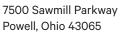
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

#### Uses and Disclosures of Health Information

To ensure we can provide you with the best care possible, we use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment - We may use and disclose your health information to obtain payment for services we provide to you.







Healthcare operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence and qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization - In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends - We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care - We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing health-related services - We will not use your health information for marketing communications without your written authorization.

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

Abuse or neglect - We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

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 3 law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminders - We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

By signing this Notice, I acknowledge that I have read and u	nderstand all of the above and agree to the statements contained within
Notice of Privacy Practices.	
Patient full name	Today's date
Patient / Responsible party signature	