InfiniteSmiles
Neal Patel, D.D.S., Inc.

7500 Sawmill Parkway
Powell, Ohio 43065
740.881.2600

Patient Information

Patient first name _____ M.I. _____ Patient last name _____

Preferred name _____

Patient SSN _____ Gender _____ Date of birth _____

Patient address _____

City _____ State _____ Zip code _____

Primary phone _____ ○ Home | ○ Cell | ○ Work Secondary phone _____ ○ Home | ○ Cell | ○ Work

Email _____

☐ I would like to receive correspondence by email.

☐ I am able to accept text messages.

Emergency contact name _____

Relationship to patient _____ Emergency contact phone _____

☐ Patient is under 18 years of age

If so, complete below for responsible party.

Responsible party name _____

Relationship to patient _____ Date of birth _____

☐ Responsible party address is same as above (if different, complete below).

Responsible party address _____

City _____ State _____ Zip code _____

How did you hear about Infinite Smiles? _____

☐ $50 referral bonus I was referred by an existing patient (patient name must match our records).

Patient who referred me _____

Primary dental insurance information

* Please provide copy of insurance card *

Name of insured _____

Relationship to patient _____ Date of birth _____

Name of insurance carrier _____

Name of employer _____

Insured SSN / Member ID _____

Group number _____

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Medical History

Patient name _____ Date of birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions and for providing information to help us better care for you as our patient.

Are you under a physician's care now?	○ Yes	○ No	If yes _____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes _____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes _____
Are you taking any medications, pills or drugs?	○ Yes	○ No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	○ No	If yes _____
Are you on a special diet?	○ Yes	○ No	
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	If yes _____

Women, are you:

☐ Pregnant / Trying to become pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Latex
- ☐ Metal (please specify) _____
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Other (please specify) _____
- ☐ Acrylic

Do you have, or have you had, any of the following?

- ☐ AIDS/ HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/ Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/ Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/ Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/ Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/ Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/ Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed? ○ Yes ○ No If yes _____

Additional comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient / Responsible party signature _____ Today's date _____

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Financial Policy

At Infinite Smiles - Neal Patel, D.D.S., Inc., we want all our guests to be able to comfortably afford dental care. We 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. Our office will 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 clients. After all treatment, we will promptly file and follow up on your dental claims to ensure 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 canceled 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 canceled and not rescheduled.

Acknowledgment 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 canceled within 48 hours of my scheduled appointment time.

Patient full name _____ Today's date _____

Patient / Responsible party signature _____

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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 - Neal Patel, D.D.S., 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.

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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 understand all of the above and agree to the statements contained within this Notice of Privacy Practices.

Patient full name _____ Today's date _____

Patient / Responsible party signature _____

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Patient Authorization and Release Form

I consent and agree that the photograph(s) or medical image(s) made of me by Infinite Smiles - Neal Patel, D.D.S., Inc. may be distributed to and used by the business for the purpose of public information or any other purpose Infinite Smiles - Neal Patel, D.D.S., Inc. deems appropriate to inform the medical profession or the general public about the field of dentistry.

I grant this consent as a voluntary contribution. I understand that such photograph(s) or medical image(s) shall become property of the business and may be shown, published, printed, broadcast or otherwise disseminated in any medium. I release and discharge Dr. Neal Patel, Infinite Smiles and all parties acting under their licenses and authorities from all rights that I may have in the photograph(s) or medical image(s), including any claim for payment in connection with their distribution or publication.

I understand that, to the extent permitted by law, I have the right to inspect and copy the photograph(s) or medical image(s) that I have authorized to be disclosed.

By signing this form, I certify that I have read the above authorization and release and fully understand its terms.

Patient full name _____ Today's date _____

Email address _____

Patient signature _____