



Artiste Dentistry LLC

We are pleased to welcome you to our practice. Please take a few minutes to complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name: (Last, First, MI) _____ Age: ____ Sex: M F
Address: _____ Apt No. _____
City: _____ State: _____ Zip: _____
Birth Date: ____/____/____ SSN: ____-____-____ Single / Married / Divorced / Widowed
Drivers License No: _____ State: _____ E-mail: _____

Home: (____) _____ - _____
Work: (____) _____ - _____
Mobile: (____) _____ - _____

Employer / Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Are any of your family members patients of this practice? Yes No Name: _____ Relationship: _____

Whom may we thank for referring you to our office? _____

Insurance Directory Other Patient Direct Mail Yellow Pages Internet Search Other

In case of emergency, contact: _____ Relationship: _____ Phone (____) _____ - _____

Primary Insurance

Person Responsible for Account: (Last, First, MI) _____

Relationship to Patient: _____

Address (if different from Patient's): _____ Apt No. _____

City: _____ State: _____ Zip: _____

Birth Date: ____/____/____ SSN: ____-____-____ Married / Single / Other

Drivers License No: _____ State: _____ E-mail: _____

Person Responsible Employed By _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group Name: _____ Plan: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Insurance Claims Dept. Address _____ Phone #: _____

Names of other dependents covered under this plan _____

Home: (____) _____ - _____
Work: (____) _____ - _____
Mobile: (____) _____ - _____

Dental History

What is the reason for this appointment? _____

Are there any specific dental problems we should be aware of? _____

Do you think you have any decay or cavities? Yes No

How often do you brush? _____

Do your gums bleed easily when brushing or flossing? Yes No

How often do you floss? _____

Do you suffer from chronic bad breath or bad taste? Yes No

Do you have any jaw joint cracking or pain? Yes No

Are you happy with the appearance of your teeth? Yes No

Have you ever considered whitening your teeth? Yes No

Do you suffer from snoring & sleep apnea? Yes No

* If "yes" please fill out "Epworth Sleepiness Scale" Form*

What was the purpose of your last dental appointment? _____ When was that? _____

When was the last time you had a dental cleaning? _____ Name of previous dentist? _____

When were the last full mouth x-rays taken of your teeth? _____

How would you describe your dental health? Excellent Good Fair Poor

Patient Treatment Consent

- I authorize the Dentist(s) or designated staff treating me or my dependents to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of any dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of **\$25 per month**.

Patient / Parent or Guardian Signature: _____ Date: _____



Patient Smile Evaluation Form

Name: _____ Date: _____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

- Do you dislike the color of your teeth? YES NO
- Do you have spaces between your teeth that bother you? YES NO
- Do you have chips or uneven edges on your teeth? YES NO
- Do you feel that your teeth are too long or too short? YES NO
- Do you have dark fillings that show when you smile? YES NO
- Do your gums show too much when you smile? YES NO
- Are your teeth crowded or crooked? YES NO
- Do you have existing crowns or dental work you consider “ugly”? YES NO
- Are you self-conscious of your teeth and/or smile? YES NO
- Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile? YES NO
- Do you avoid smiling when you have your picture taken? YES NO
- Would you like to improve your existing smile? YES NO
- Do you wish you had a “new smile”? YES NO

Place a checkmark next to which of the following are concerns you have regarding dental treatment to improve your smile:

- Fear of treatment
- Time of treatment concerns
- Financial concerns
- Distance to office
- Not understanding treatment
- Embarrassment
- Other

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

- 0 = would **never** doze
- 1 = **slight chance** of dozing
- 2 = **moderate chance** of dozing
- 3 = **high chance** of dozing

It is important that you answer each question as best you can

Situation	Chance of Dozing (0-3)
Sitting and reading _____	_____
Watching TV _____	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting) _____	_____
As a passenger in a car for an hour without a break _____	_____
Lying down to rest in the afternoon when circumstances permit _____	_____
Sitting and talking to someone _____	_____
Sitting quietly after a lunch without alcohol _____	_____
In a car, while stopped for a few minutes in the traffic _____	_____

THANK YOU FOR YOUR COOPERATION

The primary goal of our practice is to provide the highest quality dental care to our clients. Since our practice also has financial obligations which must be met, we ask you to note the following statements of our financial policy.

Important Dental Insurance Information for our Patients:

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles, and required co-payments.

Your insurance plan is a contract between you (or your employer) and the insurance company. Ultimately, patients are financially responsible for their accounts. Specific questions about eligibility and plan coverage should be directed to your insurance or your employer.

Treatment Plans and Estimates:

Treatment plans are merely estimates. We may encounter situations during the course of your planned treatment that may require different and/or additional procedures. It is often impossible to predict the *exact* cost of the treatments until they are rendered.

Our Courtesy Service to you includes:

- . Researching your dental insurance plan to advise you of benefits available to you.
- . Following the American Dental Association guidelines for coding procedures and filing insurance.
- . Filing your insurance on your behalf within 48 hours of your visit and requesting payment of your benefit to our office.

Our expectations of you as the Owner of the Policy:

- . Payment of fees not covered by your insurance plan at the time the services are rendered including deductibles and co-payments. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance. 2% Finance Charge will be applied to unpaid account balances every month.

Note: Co-payments are due at time of services rendered. Invoices are only generated for unpaid balances after insurance payments have been made on a claim.

- . Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
- . Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called *Usual & Customary Rates*) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
- . Taking responsibility for payment if the insurance company does not pay our office within 30 days.
- . Keeping our office informed of any changes in your insurance coverage or employment.

Emergency Services:

- . All efforts will be made to accommodate emergency visits as soon as possible; but in some cases patients will have to wait for the next available appointment if appointments are made over the phone or wait for more than 30 minutes or until the dentist becomes available if visiting without a prior notice.
- . Due to the nature of emergency visits, new patient emergency treatments will only be accepted if patient covers the charges of the service at the time the service is rendered.
- . Post-operative complications of another dentist's treatment will not be treated and patient should seek treatment under the care of the dentist who has initiated the treatment.
- . Medications will not be prescribed over the phone for new emergency patients that have not been visited by the dentist. Only in some established cases with patients of record medications not including heavy narcotics will be prescribed over the phone.

Termination Policies:

The dentist-patient relationship may terminate if:

- . Treatment recommendation is refused by the patient and the dentist can no longer continue to care for the patient at or above the standard of care.
- . Patient falsifies and fabricates information documented in his/her records.
- . Patient doesn't fulfill his/her financial obligations and stops making payments for services.
- . Patient misses or cancels numerous appointments.
- . Patient makes unreasonable demands on dentist and his/her staff.

In the event of termination of dentist-patient relationship, the patient will be informed & assisted during the termination of the relationship. The dentist will provide emergency care to the patient for 30 days from the date of termination.

Missed Appointment & Cancellation Policies:

. Each missed appointment without 48 hour notice in advance will be subject to \$25 per 30 minute of appointment.

***After your first missed appointment with less than 48 hour in advance notice, it is our policy to secure a down payment of \$25 per 30 minute of future booked appointments.**

- . As a courtesy to you we have a patient appointment reminder service in place. If you have any questions about your appointment or if there is any discrepancy, you should ALWAYS verify by calling our office.
- . NO responses to automated emails or messages should be made for changing or cancelling appointments!
- . Remembering your appointment date and time is ultimately your responsibility. Not getting a reminder is neither an excuse to miss your appointment nor will it invalidate your originally set appointment.
- . Rescheduling & cancelling appointments are ON LY accepted via phone calls made in person.
- . Rescheduling & cancelling appointments via text message and email are NOT accepted and will be subject to our missed appointment office policies.

Administrative Charges:

Checks returned by the bank	\$25
Finance Charge applied to unpaid balances (each month)	2%
Missed appointments per 30 min of appointment (unless notice is given 48 hours in advance)	\$25
*Down payment per 30 min of booked procedure appointment	\$25
Collection agency fee (not including attorney & court costs)	\$50

Payment Plans:

For patients who prefer a monthly payment plan, we have made arrangements with CareCredit®. There are no application fees or down payments and approval is usually provided quickly. The loan may be interest-free for up to twelve months. Applications and additional information are available from our receptionist.

I hereby authorize Artiste Dentistry LLC to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Artiste Dentistry LLC.

I have read this financial policy. I understand and agree to the terms of this financial policy.

Signature of Patient (or Financially Responsible Party)

Date

Please Read Both Pages Carefully, Sign & Date

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I have received a copy of the Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

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

Personal Representative's name: _____

Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

Artiste Dentistry LLC

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.

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 October 1, 2005, 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. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you at your next office.

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

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care and service that you receive. Your health information is contained in a medical or dental dispensary record that is the physical property of Artiste Dentistry.

How We May Use or Disclose Your Health Information

For Treatment

We may use or disclose your health information to another health care facility with specialty in oral surgery, endodontics, maxillofacial surgery, periodontics, pediatric dentists, or other healthcare providers providing treatment to you for:

- . the provision, coordination, or management of health care and related services by health care providers;
- . consultation between health care providers relating to a patient/customer;
- . the referral of a patient for health care from one health care provider to another; or
- . appointment reminders and recall information.

For Payment

We may use and disclose your health information to others for purposes of processing and receiving payment for treatment and services provided to you. This may include:

- . billing and collection activities and related data processing;
- . actions by a health plan or insurer to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims;
- . medical necessity and appropriateness of care reviews, utilization review activities; and
- . disclosure to consumer reporting agencies of information relating to collection of payments.

For Health Care Operations

We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to:

- . evaluate the performance of our associates;
- . assess the quality of service, product and care in your case and similar cases;
- . learn how to improve our facilities and services;
- . conduct training programs or credentialing activities; and
- . determine how to continually improve the quality and effectiveness of the products, service and care we provide.

Appointments, Treatment and Quality Assurance

We may use your information to provide appointment reminders or recall notices (such as voicemail messages, postcards or letters) or information about treatment alternatives or other health-related benefits, products and services that may be of interest to you. We may also contact you to conduct our own surveys about the quality of the products and services we provide.

To You, Your Family and Friends

We must disclose your health information to you, as described in the Your Health Information 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 or, if you are not able to agree, if it is necessary in our professional judgment.

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 or your general condition. 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 judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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, photos, x-rays, or other similar forms of health information.

Required by Law

We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- . for judicial and administrative proceedings pursuant to legal authority;
- . to report information related to victims of abuse, neglect or domestic violence;
- . to assist law enforcement officials in their law enforcement duties; or
- . to assist public health officials avert a serious threat to the health or safety of you or any other person.

Decedents

Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation

Your health information may be used or disclosed for cadaver, organ, eye or tissue donation purposes.

Research

We may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Government Functions

Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Worker Compensation

Your health information may be used or disclosed in order to comply with laws and regulations related to Worker Compensation.

Marketing Health Products or Services

We will not use your health information for marketing communications without your prior written authorization. We may, however, provide you with information regarding products or services that we offer related to your health and oral care needs. We will never sell your health information without your prior authorization.

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.

YOUR HEALTH INFORMATION RIGHTS**Access:**

You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You may be asked to make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice setting forth the specific information to which you desire access. If you request an alternative format, provided that it is practicable for us to produce the information in such format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting:

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosures made prior to April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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. You may obtain a form to request an amendment to your health information by using the contact information listed at the end of this Notice.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Information

If you have any questions or complaints, please contact:

Artiste Dentistry LLC
46090 Lake Center Plaza, Suite 107
Phone: 703-434-3286
Email: Info@ArtisteDentistry.com

Thank you for entrusting Artiste Dentistry LLC with your dental and oral care needs.