

# Jack O. Smalley, DDS, PC

Preventative, Restorative, Cosmetic Dentistry

1700 N. BUTLER • FARMINGTON, NM 87401  
505-327-3331 • FAX 505-327-0873

*" We Care about People, Not Just Teeth"*

Our dental team is happy to welcome you to our dental practice. We are pleased that you have chosen us for your oral health. We want you to know that our dental team is committed to providing you with the highest quality of dental treatment, and we will do so in a gentle, efficient, and knowledgeable manner.

The first visit to our office will consist of a complete oral examination. We will be taking x-rays and performing any other tests that are needed to make a complete diagnosis of the condition of your mouth, teeth and gums. We will then be able to determine the treatment required.

We place a high priority on time in our practice and we will always try to be prompt. Please note if you need to reschedule an appointment we request 72-hour's notice to allow us time to contact another patient needing care.

Please fill out the enclosed health questionnaire as completely as possible and bring it to your first appointment. This is to ensure that we provide complete and careful dental care.

We all look forward to meeting and having you in our practice.

Sincerely,

Dr. Jack Smalley and Staff

### PATIENT REGISTRATION

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_

Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired

Emergency contact: \_\_\_\_\_

Student Status:  Full Time  Part Time

Cell phone: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Referral source: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

MEDICAL HISTORY FOR

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.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

- Are you allergic to any of the following?
Aspirin, Penicillin, Codeine, Acrylic, Metal, Latex, Local Anesthetics
Other If yes, please explain:

- 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 Problem, 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 Pace Maker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, 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 above? If yes, please explain:

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

## DENTAL HEALTH EVALUATION

1) Are you having problems with your teeth, or is anything bothering you at this time?

Yes\_\_No\_\_

If so what-\_\_\_\_\_

2) How long since you have last seen a dentist? \_\_\_\_\_

3) Are you pleased with the appearance of your teeth? Yes\_\_\_\_No\_\_\_\_ Is there anything you would like to change? Yes\_\_No\_\_\_\_ Specific concerns or changes desired

\_\_\_\_\_

4) Are your teeth as white as you would like them to be? Yes\_\_No\_\_\_\_

5) Do you pack food between any teeth while chewing? Yes\_\_No\_\_\_\_

6) Are your teeth sensitive to Hot?\_\_\_\_\_ to Cold\_\_\_\_\_ to Chewing\_\_\_\_\_

7) Are you aware of any problems with your gums? Yes\_\_\_\_No\_\_\_\_

8) Are your gums sore, or do they bleed when you brush / floss? Yes\_\_No\_\_\_\_

9) Do you have any missing teeth? Yes\_\_No\_\_ Has anyone suggested replacing them? Yes\_\_No\_\_

What was recommended?

\_\_\_\_\_

10) Are you apprehensive or uncomfortable about dental treatment? Yes\_\_No\_\_\_\_

11) How do you feel about keeping your natural teeth for a lifetime?

High\_\_\_\_Medium\_\_\_\_Low\_\_\_\_

12) In order of priority, which of the following would prevent you, -or- be a barrier to you, in considering dental treatment?

- \_\_\_ Fear of treatment itself
- \_\_\_ Time away from work
- \_\_\_ Financial concern
- \_\_\_ Lack of importance or concern for your teeth

Signature \_\_\_\_\_ Date \_\_\_\_\_

## PAYMENT POLICIES FOR OUR OFFICE

- WE WILL BE HAPPY TO PROCESS CLAIMS FOR YOU TO YOUR INSURANCE COMPANY, ALTHOUGH ANY ESTIMATED PATIENT PORTION IS TO BE **PAID AT TIME OF SERVICE.** (We do not accept Medicaid)
- WE ALSO OFFER 2 EQUAL PAYMENTS OF ANY PATIENT PORTION DUE, THE FIRST HALF IS DUE AT TIME OF SERVICE, THE REMAINING BALANCE IS DUE WITHIN 30 DAYS.
- IF YOU NEED OR WOULD LIKE TO MAKE SMALLER MONTHLY PAYMENTS WE OFFER THAT WITH CAPITAL ONE HEALTHCARE FINANCE. THEY OFFER PLANS UP TO 18 MONTHS INTEREST FREE. THEIR NUMBER IS 1-877-559-5050. THIS MUST BE DONE AND APPROVED BEFORE ANY TREATMENT IS STARTED.

ANY PAYMENT CAN BE MADE BY CASH, CHECK, MONEY ORDER-----WE ALSO ACCEPT MASTERCARD VISA and DISCOVER.  
ACCOUNT BALANCE THAT REACHES 60 DAYS PAST DUE WILL BE CHARGED AN INTEREST RATE OF 21% PER MONTH.

## HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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.  
You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. You may obtain a copy of our Notice of Privacy Practices at any time by contacting our office at (505)327-3331.

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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 health care operations.

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

Personal representative's name \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records to carry out treatment, to obtain payment, and those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records to the following persons who are involved in my care or payment for that care. \_\_\_\_\_

I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

Patient's or Guardian's

Signature \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL INSURANCE

### DO YOU UNDERSTAND YOUR POLICY?

During the past decade, dental benefit plans have become an integral part of health care planning for many patients. Dental benefit plans are made available to employees or members through companies, unions, and associations and vary considerably from one plan to the next. The range of benefits depends solely on what the purchaser wishes to offer their employees or members. **If your employer purchases a limited policy, your coverage is limited.**

Some plans pay or base their amount of benefit on a scheduled amount pre-determined by insurance companies based on their profit margins and ability to compete with other insurance companies. For this reason, you may receive a lower percentage of the reimbursement level than indicated in your dental plan. For example, if your plan indicates it will pay 80%, it usually means 80% of **their** pre-determined amount, not the actual fee charged in our office.

Out of this insurance coverage have come certain assumptions and you are important to us, therefore, we would like to make the principles of our office very clear, as well as the type of service and care we provide for our patients clear, to avoid and misunderstandings.

Our fees are based on the overhead involved in this practice, the treatment plan selected, and the time and quality that it takes us to provide you with excellent care. **Some of the services that we provide are not covered by insurance at all.** We do not believe that it is in either of our best interests for us to compromise our recommended treatment in order to accommodate an insurance company's maximum benefits that may considerably less than optimal. **We are committed to the very best care for you.** However, we are more than happy to discuss a treatment plan's advantages and disadvantages with you thereby involving you, rather than the insurance company, in the decision making process. It is our responsibility to make certain that you understand the consequences of non-treatment. Treatment that is needed doesn't go away, and treatment options can change over time, however, the treatment you select is your decision.

- As a courtesy to you, we will complete the dental portion of your claim form. To expedite processing, please make sure your personal information is completely up to date. **If you have changes in coverage or carriers, please notify us immediately.**
- If coverage is verified and arrangements are agreed on in advance, as well as you directing the insurance company to pay it's estimated share of cost direct to our office, you will receive credit for this pending payment. **However, your estimated co-payment responsibility is due at the time of service. We allow 60 days for the insurance company to issue payment to us.** If they have not within this time, you will be billed and payment then becomes your full responsibility. If payment has been received, we will reconcile the amount on your account and refund any possible overpayment promptly. We do want to work with your insurance; however, we feel that 60 days is adequate time for any company to process payment. The last thing we ever want is a financial misunderstanding with any patient. We stress that **the financial obligation for all dental treatment is always between you and our office.** Your insurance company is responsible to you and not to our office, since your contract is between you and them. We are accepting "Assignment of Benefits" as a courtesy to you to reduce your immediate out-of-pocket expenses.
- IF you feel that the dental benefits provided by your plan are inadequate, you may want to discuss this matter with your employer, union, or association, so that alternatives may be investigated. **We promise to file your claims efficiently to maximize every penny which you are entitled to under your plan,** yet we have no control over how or what your plan covers. That was determined when the plan was purchased and was determined by your employer and the insurance company

We are here to help you. Please call or stop by with any questions we can clarify. We encourage open communication to avoid any misunderstandings or delays in processing and payment for your dental plan.

I have read and understand my obligation of payment.

Name \_\_\_\_\_ Date \_\_\_\_\_