Welcome to Bright Smiles

Patient Information

Name: _____ Today's Date: ____
Social Security Number: _____ Date of Birth: _____
Address: _____ City: _____State: ____
Zip:_____
Sex: ___Male ___ Female E mail: _____
Home Phone: _____ Cell: _____ Work: _____
Where do you prefer to receive calls? _____
Patients Employer/School:_____Occupation:_____
Employer's Name: _____
Spouse or Parent's Name: _____
Who may we call in case of an emergency? _____
Phone:_____

Who may we thank for referring you to us? _____

Insurance Information

Name of Insured:_____ Relationship to Patient:_____
Birthdate:_____ Social Security Number:_____
Name of Employer:_____Office Phone:_____
Insurance Company:_____
Group Number:_____ Employee ID:_____

Do You have Secondary Insurance? ____ Yes ____No
Name of Insured:_____ Relationship to Patient:_____
Birthdate:_____ Social Security Number:_____
Name of Employer:_____ Office Phone:_____
Insurance Company:_____
Group Number:_____ Employee ID:_____

Medical History: Do you have or had any of the following...(circle)

AIDS	Diabetes	Psychiatric Care
Anemia	Epilepsy	Radiation Therapy
Arthritis	Glaucoma	Sinus Problems
Artificial Heart valve(s)	Heart Murmur	Stroke
Asthma	Heart Attack	Steroid Therapy
Back Problems	Hepatitis	Tobacco Habit
Bleeding Abnormalities	High Blood Pressure	Tuberculosis
Blood Disease	HIV Positive	COPD
Cancer	Joint Replacement	Pacemaker
Chemical Dependency	Kidney Disease	
Chemotherapy	Liver Disease	

Are there any other health conditions that you have that are not listed?_____

_____Medications:_____

_____

Allergies: _____

Women Only:

Are you Pregnant? _____Yes __ No Nursing?__Yes __No___

Physicians Name:_____ Physical Date:_____

Dental History

Date of Last Exam:_____ Reason for today's Visit:_____

Please circle all that apply to your oral health.....

Bad Breath	Grinding/Clenching teeth	Hot/Cold Sensitive
Bleeding Gums	Loose Teeth	Sweet Sensitive
Jaw Pain	Past Perio Treatments	Biting Sensitive
Sores or Growths	Broken fillings or teeth	Oral biopsy history

Certification & Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health. I certify that I or my dependents have insurance coverage with _____ and assign Bright Smiles, LLC all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claims.

Signature: _____ Date: _____

Bright Smiles
Financial and Appointment Policy

Insurance

As a courtesy to our patients Bright Smiles will file your dental insurance for you on your behalf. Your Co-pay and/or portion are due the day of service. If you do not have dental insurance payment in full is expected unless financing is arranged prior to treatment. Please feel free to ask our staff for estimates on your future treatment.

Appointments

If for some reason an appointment needs to rescheduled please do so at least 24 hours in advance. If an appointment is missed or canceled the day of appointment a fee of $50 per hour for daytime appointments and $100 for appointments 4:00 pm and later scheduled may be charged to your account.

Collections

If a balance is not paid in full after all insurance has been collected then the practice has no choice but to send the account to a collection agency. If the account is sent to a collection agency a fee will be added to the balance due to cover collection agency fees.

This acknowledges that I have reviewed the above policies.

*Signature:*_____

*Date:*_____

Bright Smiles, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCOLOSED 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, which has information pertaining to our legal duties, and your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 5/12/2015, 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, as long as such changes are permitted by federal and state law. We reserve the right to make the changes in our privacy practices and the new terms or 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 a significant change in this policy, we will change this notice and make the new notice available for those requesting it. You may request a copy of our notice at any time. For additional copies or more information regarding our privacy practices please contact us using the information listed at the end of this notice.

Uses And Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.
For your treatment we may use of disclose your health information to a physician or other healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment (especially form third parties or insurance companies) for services we provide to you. We may use and disclose your health information in connections with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We will not use your health information for marketing purposes without your written authorization. We may use or disclose your health information when we are required to by law.

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 family member, your personal representative or another person responsible for your care, of you 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 you incapacity or emergency circumstances, we will disclose health information 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, radiographs, or other similar forms of health information.

Appointment Reminders

We may disclose your health information to provide you with appointment reminders (voicemail, messages, postcards and letters)

Abuse or Neglect

We may disclose 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 any other crime. We may disclose your health information to the extent necessary to avert a serious threat of anyone's health or safety.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access -You have the right to look at or get copies of your health information, with limited exceptions. To obtain copies you must make that request in writing, only legal guardians or minors can obtain records. A form for records request can be obtained 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. If you request copies, there will be a charge of $0.50 per page and $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format for your records, we will charge a cost-based fee for providing your health information in that format. If you prefer a summary or an explanation of your health information can be summarized 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 disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2007. 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.

Alternative Communications – You have the right IN WRITING to request that we communicate with you about your health information by alternative means or locations. Your request must specify which 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, IN WRITING, to request that we amend your health information. We may honor or deny your request depending upon the circumstances.

Electronic Notice– If you receive this notice on our web site or by 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 any questions or concerns, please contact us.

Contact Officer: Lori Logsdon, DDS
Telephone: (636) 724-1199
Fax: (636) 724-1218
Address: 3771 New Town Blvd,
St. Charles, MO 63301

If you are concerned that we may have violated you 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 use 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 at Office for Civil Rights U.S. Department of Health & Human Services 601 East 12th Street - Room 248 Kansas City, MO 64106 (816) 426-7278; (816) 426-7065 (TDD) (816) 426-3686 FAX with no retaliation from us. For more information you can use the world wide web at www. hhs.gov.

Acknowledgment Of Privacy Practices

Bright Smiles, LLC

This statement acknowledges that I have received a copy of the privacy practices set forth by Bright Smiles, LLC

Name: _____

Legal Guardian: _____

Signature: _____

Date: _____