



801-423-7969  
 601 N. State Road 198, Salem UT 84653  
 www.GreatSalemSmiles.com

**Patient Information Form**

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

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

Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Responsible Party's Birthday: \_\_\_\_\_ Responsible Party's Social Security No.: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Responsible Party's Work Place: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Group #:** \_\_\_\_\_  
**Subscriber ID:** \_\_\_\_\_

<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>If female please answer the following:</b>	<b>Please answer the following:</b>																
	<table border="1"> <tr> <td><b>Y N</b></td> <td><input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills?</td> <td><input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?</td> <td>Height: _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If Yes, # of weeks <input type="text"/></td> <td colspan="2"><b>For Office Use Only</b></td> </tr> <tr> <td></td> <td><input type="checkbox"/> <input type="checkbox"/> Are you nursing?</td> <td>BP <input type="text"/></td> <td>Heart Rate: <input type="text"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Weight: _____</td> </tr> </table>	<b>Y N</b>	<input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills?	<input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?	Height: _____		<input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If Yes, # of weeks <input type="text"/>	<b>For Office Use Only</b>			<input type="checkbox"/> <input type="checkbox"/> Are you nursing?	BP <input type="text"/>	Heart Rate: <input type="text"/>				Weight: _____	
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	<input type="checkbox"/> <input type="checkbox"/> Are you nursing?	BP <input type="text"/>	Heart Rate: <input type="text"/>															
			Weight: _____															

Y N	Conditions	Y N	Conditions	Y N	Conditions
<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	Artificial Bones	<input type="checkbox"/>	Hepatitis B		
<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	High Blood Pressure		
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	HIV+ AIDS		
<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Kidney Problems		
<input type="checkbox"/>	Cancer- Chemotherapy	<input type="checkbox"/>	Liver Disease		
<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Low Blood Pressure		
<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	Mitral Valve Prolapse		
<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	Pace Maker		
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Pneumocystitis		
<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	Psychiatric Problems		
<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	Radiation Therapy		
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Rheumatic Fever		
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Seizures		
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Shingles		
<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	Sickle Cell Disease		
<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Sinus Problems		

  

Y N	Allergies
<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	Codeine
<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	Latex
<input type="checkbox"/>	Metals
<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	Other
_____	
_____	
_____	

**Medications:**

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?  
If yes, please describe below...

**Notes:**

**Dental History**

**Reason for Visit:** \_\_\_\_\_

**Date of Last Dental Visit:** \_\_\_\_\_

**Please Check all that apply:**

<input type="checkbox"/>	TMJ/pain in jaw jointy	<input type="checkbox"/>	Gum Recession	<input type="checkbox"/>	Sensitivity to sweets
<input type="checkbox"/>	Gums bleed easily	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	Periodontal/gum treatment
<input type="checkbox"/>	Broken teeth or fillings	<input type="checkbox"/>	Sensitivity to hot and/or cold	<input type="checkbox"/>	Sores/lumps in or near mouth
<input type="checkbox"/>	Pain/aching in teeth	<input type="checkbox"/>	Clench or grind teeth	<input type="checkbox"/>	Dentures or partials
<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	Clicking/jaw popping	<input type="checkbox"/>	

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(If under 18, Parent or Guardian Signature Required)

## Financial Policy

- 1) We accept cash, checks, Visa, MasterCard, American Express and Care Credit.
- 2) A fee of \$25 will be charged for any returned check.
- 3) Your estimated portion of service rendered is due the day of service. We will bill your insurance, and upon processing will bill if further balance is due. We will also promptly refund money if our initial estimation was inaccurate.
- 4) Any balance over 90 days will be subject to a collection fee and will then be turned over to a collection agency unless previous arrangements have been made.

## Privacy Policy

I have been given the opportunity to evaluate the privacy policies of Salem Smiles. A separate form regarding my patient rights, as pertains to the rules and regulations of HIPAA (Health Insurance Portability and Accountability Act), has been provided to me (available online or at check-in, as well as upon request). I authorize Salem Smiles to use or release health information to third party payers or other health practitioners as reasonably necessary for my treatment and reimbursement thereof.

I, the patient or responsible third party, understand and agree to the above office policies.

Name (Please Print): \_\_\_\_\_

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



**HIPAA OMNIBUS RULE**  
**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**  
 You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

\_\_\_\_\_  
 Please **print** name of Patient(s)

\_\_\_\_\_  
 Please **sign** for Patient(s) / Guardian of Patient(s)

\_\_\_\_\_  
 Legal Representative / Guardian

\_\_\_\_\_  
 Relationship of Legal Representative / Guardian

Any other additional family members covered by this agreement: \_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

- First Name Only    Proper Sir Name    Other \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- |  |   |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> <b>Any of the Above</b>            |
| <input type="checkbox"/> Text Message  | <input type="checkbox"/> <b>None of the above</b> (opt out) |
| <input type="checkbox"/> Email         |   |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- |  |       |
|--|-------|
| It was emergency treatment               | _____ |
| I could not communicate with the patient | _____ |
| The patient refused to sign              | _____ |
| The patient was unable to sign because   | _____ |
| Other (please describe)                  | _____ |

\_\_\_\_\_  
 Signature of Privacy Officer