



Today's Date _____

Patient's Name _____ Social Security No. _____

What would you like to be called? _____ Birth Date _____ Age _____

Address _____

City _____ State _____ Zip _____ Home Phone (____) _____

Email _____ Cell Phone (____) _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

In case of emergency, contact _____ Phone (____) _____

How did you hear about our office? _____

Please state briefly the reason for your visit _____

Have any family or friends been treated here? _____

DENTAL INSURANCE INFORMATION Insurance Card **must** be provided for proper filing of claims.

Responsible Party _____ Relationship to Patient _____

Address _____

Social Security Number _____ Birth Date _____ Cell Phone (____) _____

Employer _____ Work Phone (____) _____

Employer Address _____

DENTAL HISTORY Please answer all questions by putting a ✓ in the appropriate box.

Yes No
 Are you having any discomfort at this time? If yes, explain _____

 Have you previously been seen by a dentist? If yes, please provide the following information:
Provider Name: _____
Address of Previous Provider: _____
Phone:(____) _____ Date of last appointment: _____

 Do you clench or grind your teeth?

Have you had any of the following dental treatments:

 Orthodontics (braces)

 Oral (jaw) surgery

 Periodontal Treatment

Do you have questions or concerns? _____

Updated Medical History

Patient Name: _____

Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, health problems that you may have, or medications that you may be taking could have an important interrelationship with the dentistry you will receive. We ask that our patients update this form annually so that we can provide them with the best possible treatment. Thank you in advance for your cooperation.

Address _____

City _____ State _____ Zip _____ Home Phone (____) _____

Email _____ Cell Phone (____) _____

Circle your answer

| | | | |
|---|-----|----|-------------------------------|
| Are you under a physician's care now? | Yes | No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation? | Yes | No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury? | Yes | No | If yes, please explain: _____ |
| Do you use tobacco? | Yes | No | If yes, please explain: _____ |
| Do you use controlled substances? | Yes | No | If yes, please explain: _____ |

Women: Are you

| | | | | | | | | |
|----------------------------------|-----|----|-----------------------------|-----|----|----------|-----|----|
| Pregnant/Trying to get pregnant? | Yes | No | Taking oral contraceptives? | Yes | No | Nursing? | Yes | No |
|----------------------------------|-----|----|-----------------------------|-----|----|----------|-----|----|

Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic

Metal Latex Sulfa drugs Other If yes, please explain: _____

Do you have, or have you had, any of the following? **ONLY check if they apply to you**

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

Have you ever had any serious illness not listed above? Yes No _____

Please list all medications you are currently taking (including all over the counter): _____

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 or Guardian

Date



Office Policies

The nature of our practice is to provide our patients the utmost care and comprehensive service. Please excuse any delays and be assured we will give you careful attention as soon as possible. The following policies apply to all patients at Calm Waters Dentistry. **Please read and let us know if you have any questions prior to signing below.** A copy will be provided for your records.

Appointments: Your appointment time has been reserved specifically for you. Appointments are necessary to ensure that each of our patients receives the appropriate attention and level of comprehensive care they need. If you are unable to keep a scheduled appointment, we ask that you provide our office with **at least 24 hours' notice** so that your previously reserved time can be given to another patient on the waiting list. We understand there may be circumstances that do not allow for a 24-hour notice, but please call as soon as any need to change your appointment arises.

Confirmation of Appointments: We will make every effort to contact you 24-48 hours prior to your appointment to provide you with a reminder, however, it is the patient's responsibility to remember their appointments. To aid in this process, please keep your contact information up to date with our office. In the event we are unable to confirm your appointment, your appointment time may be given to another patient and your appointment will need to be rescheduled. If you believe you have an appointment but have not received a call from our office, don't hesitate to give us a call.

Late or Broken Appointments: If you are going to be more than five minutes late for an appointment, please notify us you are running late. We schedule our appointments to allow enough time for the procedures scheduled. If you are late, we may not be able to complete the scheduled treatment, or it may put us behind for the patients scheduled after you. A broken appointment is when a patient does not show up for their appointment or gives less than 24-hour notice. After three broken appointments, we may have to consider dismissing you from the practice.

Dental Radiographs: Dental radiographs allow us to properly diagnose for periodontal disease, cysts, cancerous and non-cancerous tumors and tooth disease. We must have adequate and current radiographs in order to plan your treatment appropriately. We follow the guidelines of the ADA (American Dental Association) which recommends a full mouth series of radiographs or a panoramic radiograph every 3-5 years for every patient. We will also update bitewing radiographs every year. The ADA guidelines state that "dentists have an obligation to maintain and enhance a patient's oral health within the standard of care, and from a liability standpoint a patient cannot consent to treatment that is outside that stand of care." We will do our best to work with your insurance company if their frequency limitations are different. Upon becoming a new patient, we will accept radiographs taken at a previous dental office within the specified guidelines.

Treatment Plans: We will provide you with an estimate of costs for your needed treatment. Costs can sometimes change as treatment progresses or with the ongoing evaluation of your dental care. We will always make you aware before starting any procedure.

Insurance Policy: Treatment of our patients is not based on their insurance. It is based on your medical and dental history, oral examination, and communication of a proper dental treatment plan. Calm Waters Dentistry is an out of network provider with all insurance companies and we do not participate with Medicaid/Medicare or any insurance discount plans. If your insurance policy requires that you see a participating provider only, they will not pay our office. Because dental insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee what your insurance plan will cover. We may require payment for your estimated portion at the time of service.

As a service to our patients, we will file your insurance claims and do our best to communicate and provide all needed information to ensure prompt payment of a claim. We allow 60 days for the insurance company to pay us their percentage for dental services rendered. After this time period, you will receive an invoice from our office and are responsible for the balance due in full. If your insurance company does not respond or cover the claim, you can appeal the claim directly with your insurance company. As an out of network provider, some insurance companies will pay you directly as the patient. In this case, we may collect payment in full on the date services are rendered.

Please keep in mind that your insurance is a contract between you and the insurance company/employer. As such, you are responsible for your account including understanding your insurance benefits, deductibles and coverage details. Please notify us of any insurance changes, additional policies (secondary policies) or any other out of the ordinary changes that may prevent the insurance company from processing your claim.

By signing this policy, you authorize release of any information relating to your claims and authorize payment directly to Calm Waters Dentistry and/or Dr. Nicholas Wentworth of the group insurance benefits otherwise payable to you. Your signature confirms you understand that you are responsible for the cost of all dental services rendered.

Payments: If you have dental insurance, we will need to confirm coverage **prior** to your visit if applicable. If we have not received this information prior to the day of your visit, you may be required to pay the entire balance on the day of service. We will discuss your treatment plan and payment schedules at your initial consultation. For major services such as root canals, crowns, dentures, or implants, we typically collect 50% at the first appointment and the balance at the last appointment or when the final product is delivered. If you need to set up a different arrangement for these services, please let us know. No final product will be delivered if there is a remaining balance on the account.

We accept cash, personal checks, and all major credit cards. We do not offer in-house payment plans. Statements will be sent every 30 days, if no payment has been made in the last 30 days on an outstanding balance. If no payment is received on your account after three statements, future appointments may be cancelled and your account given to a collection agency. A \$30 fee will be charged if your account is required to be sent to collections.

Please sign below if you have read and understand our office policies. We appreciate your business and look forward to serving you!

Signature

Date

Office Policies Patient Summary

Appointments

- Please make every effort to keep your scheduled appointment time. We request 24-hour notice if you need to change or cancel your appointment. **There will be a \$75 Fee, if not cancelled prior to a 24-business day notice.**
- We will make every effort to remind you of your appointment 24-48 hours in advance. We appreciate your cooperation in confirming your appointment. If an appointment remains unconfirmed, we may give the spot to another patient.
- Please keep your contact information up to date with the office.
- Please notify us if you are going to be more than 5 minutes late for an appointment. We may have to reschedule the appointment if there is not enough time for the scheduled procedure.
- Multiple broken appointments (less than 24 hours' notice of change) may result in dismissal from the practice.

Dental Radiographs

- Adequate and current radiographs are necessary to plan your treatment appropriately. Radiographs are required to be a patient in our office.
- We follow ADA standards for radiographs. We will update bitewing radiographs annually and full mouth/panoramic radiographs every 3-5 years to ensure the best care.

Insurance

- As a service to our patients, we will file your insurance claims and do our best to communicate and provide all needed information for claims.
- We are not in-network with any insurance companies or Medicare/Medicaid, and we do not participate with discount cards.
- Please provide your insurance information prior to your appointment and update us with any changes of insurance company or plan.
- You are responsible for knowing your insurance coverage details, deductibles and benefits.
- You are responsible for any portion of the services rendered to you not covered by your insurance.

Payments

- We accept cash, personal checks and all major credit cards. We do not offer in-house payment plans.
- For major services such as dentures, crowns, root canals, and implants, 50% is due at the first appointment and balance must be paid in full prior to delivery.
- Statements will be sent every 30 days. After 90 days with no payment, your account may be sent to collections, for which a \$30 fee will be charged.

We appreciate your business and look forward to serving you!



PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient's Name: _____

Relationship to Patient: _____

Signature: _____



PATIENT REQUEST FOR X-RAYS AND/OR RECORDS

To: _____

Attn: _____

Street Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

I hereby authorize the release of my x-rays and/or records or copies of such and request that they are transferred to Calm Waters Dentistry. Please email records and images to info@calmwatersdentistry.com.

Print Patient's Name

Patient's Signature

Patient's Date of Birth

Date



Calm Waters

DENTISTRY & IMPLANTS

I, _____, give the following people permission to discuss my treatment options and my payment options.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

The person in charge of my account is: _____

Address if different from my own: _____

Signature: _____

Date: _____



Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

I have received a copy of the Notice of Privacy Practices for the above-named practice.

Signature: _____ Date: _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

 Other: _____

Prepared By: _____

Signature: _____

Date: _____



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY CALM WATERS DENTISTRY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost-based fee. We will provide this information as soon as possible but no later than 30 working days before the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list of the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost-based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share your information other than what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES – For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases, you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
 - Marketing purposes
 - Sale of your information
 - Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you.

Example: We may share your health information with an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities.

Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information: We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

• **Help with public health and safety issues:** We can share health information about you for certain situations, such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.

• **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.

• **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.

• **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.

Address workers' compensation, law enforcement, and other government requests:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

• **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.

• **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Office Manager

management@calmwatersdentistry.com

704-660-5955, 704-881-0990

Effective date: 03/14/2023