Dear _____,

Welcome! We want to start by thanking you for choosing Lisbon Smiles. We recently scheduled an appointment for you with Dr. Nelson on _____ at _____.

When you arrive here for your visit, we know you'll have a lot of things on your mind. We don't think that paperwork should be one of them! Since paperwork is necessary, we'd like to help you get it out of the way *now*. Later, when you come for your appointment, the paperwork will be done and we can focus on what really counts—your care and comfort.

With this in mind, **please take a few minutes to fill out the enclosed forms**. When you're done, simply drop them in the mail. We have provided a self-addressed, stamped envelope for your convenience.

Thank you for taking the time to complete these forms now. If you have any questions, please call us at 701-683-7695 or toll free at 1-866-683-4654.

To get to know us better, please visit us on our Facebook page and our Website at: www.lisbonsmiles.com.

We look forward to seeing you!

Dr. Ryan M. Nelson and staff

Welcome to Lisbon Smiles

Thank you for choosing us as your Dental Healthcare Providers. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Today's Date: _____

Wishes to be called: _____ Birth Date: _____ / _____/ _____
Social Security Number: _____ Male / Female (Please Circle One)
Address: _____ Marital Status: Single Married Divorced (Please Circle One)
City: _____ State: _____ Zip: _____ E-Mail: _____
Patient (or Parent) Employer: _____ Occupation: _____

WHO MAY WE THANK FOR INVITING YOU TO OUR PRACTICE?
NAME:_____ **OTHER:**_____

Telephone

Home Phone: _____ Work Phone: _____ Ext: _____
Cell Phone: _____
Where do you prefer to receive calls? O Home O Work O Cell
When is the best time to reach you? Time _____ Days _____
Emergency contact: Name _____ Relationship _____ Number _____
Preferred Method of Contact: O Phone O Email O Text

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Birth Date: _____ / _____/ _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Work Phone: _____ Ext: _____ Cell Phone: _____
O **Responsible Party is also a Policy Holder:** Primary Secondary (please circle one)

Insurance Information

Primary Dental Insurance	**Secondary Dental Insurance**
Name of Insurance Co: _____	
Phone # of Insurance Co: _____	Name of Insurance Co.: _____
Co. Address: _____	Co. Address: _____
Plan/I.D No. _____	Plan/I.D No. _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Date of Birth: _____	Policy Holder's Date of Birth: _____
Policy Holder's SSN: _____	Policy Holder's SSN: _____
Policy Holder's Employer: _____	Policy Holder's Employer: _____

Authorization and Release

The following release will allow us to share pertinent information regarding your care to enhance your treatment and/or financial reimbursement for services received:

1. I authorize Lisbon Smiles to share information regarding my course of treatment and the services received with my referring medical and dental providers in order to enhance my continuing treatment and care.

2. I authorize Lisbon Smiles and/or any other provider or supplier of services in this office to release any information required to secure payment for services received or the payment of benefits on my behalf. I authorized the use of the signature on all insurance submissions.

3. I understand that I am financially responsible for all charges, whether paid or not by insurance, and for all services rendered on my behalf or on behalf of my dependents.

4. I acknowledge I have received a copy of this office's Notice of Privacy Practices.

X _____

Signature of Patient or Parent/Guardian if minor Date

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

O Payment in full at each appointment

O Payment in full with credit card.

O Payment in accordance with Lisbon Smile's financial policy.

Late Charges

If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental services unless arrangements have been made.

In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

X _____

Signature of Patient or Parent/Guardian if minor Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask - we are always happy to help.

Health History

Name _____ **Birth date** _____ **Today's Date** _____

Dental History

1. Reason for today's Visit:
2. When was your last dental visit?
3. How often do you brush your teeth?
4. What texture brush do you use? O Soft O Medium O Hard
5. Do your gums bleed while brushing? Y N
6. Do your gums bleed while flossing? Y N
7. Do you feel pain in any of your teeth when you are brushing or flossing? Y N
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? Y N
9. Have you noticed any loosening of your teeth? Y N
10. Does food tend to become caught between your teeth? Y N
11. Do you have any sores or lumps in or near your mouth? Y N
12. Have you ever experienced any of the following?
    a. Clicking? Y N
    b. Pain (joint, ear, side of face)? Y N
    c. Difficulty in opening or closing? Y N
    d. Difficulty in chewing? Y N
13. Do you snore? Y N
14. Have you had any head, neck, or jaw injuries? Y N
15. Do you have frequent headaches? Y N
16. Do you clench or grind your teeth while awake or asleep? Y N
17. Do you bite your lips or cheeks frequently? Y N
18. Have you ever had:
    a. Orthodontic treatment (braces)? Y N
    b. Oral surgery? Y N
    c. Gum treatment? Y N
    d. Your teeth ground or the bite adjusted? Y N
19. Are you satisfied with the appearance of your teeth? Y N
20. Have you ever had an upsetting experience in the dental office? Y N
21. Is there anything about having treatment done that bothers you? Y N

Medical History

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 inter-relationship with the dentistry that you will be receiving. Thank you for answering the following questions.

1. Are you in good health? Y N
2. Have there been any changes in your general health in the past year? Y N
3. Date of your last physical exam:
4. Physician's name:
   Address:
   Phone number:
5. Are you now under a physicians care? Y N
6. Have you ever been hospitalized for any surgical operation or serious illness? Y N
7. Are you taking any medicine(s) including nonprescription medicine: Y N

PLEASE LIST ALL MEDICINE(S):

8. Have you ever taken Fen-Phen/Redux? Y N
9. Have you had any abnormal bleeding? Y N
10. Do you bruise easily? Y N
11. Have you ever required a blood transfusion? Y N
12. Have you had a recent weight loss? Y N
13. Do you use drugs or other substances for recreational purposes? Y N
14. Do you use tobacco-Smoking? Snuff? Chew? Y N
15. Do you drink alcoholic beverages? Y N
16. Do you have a persistent cough or throat clearing? Y N
17. Do you wear contact lenses? Y N
18. Do you have any disease, condition, or problem not listed above that you think we should know about? Y N

Women Only:

1. Are you pregnant or think you may be pregnant? Y N
2. Are you nursing? Y N
3. Are you on any form of birth control? Y N

Medical History Continued

Are you allergic to or have you had reactions to:

1. Local anesthetics like Novocain?	Y	N
2. Penicillin? Other antibiotics?	Y	N
3. Sulfa Drugs?	Y	N
4. Barbiturates, sedatives, sleeping pills?	Y	N
5. Aspirin?	Y	N
6. Metals?	Y	N
7. Latex?	Y	N
8. Codeine?	Y	N
9. Other? _____	Y	N

Do you have or have you ever had the following:

1. Rheumatic heart disease or Rheumatic fever?	Y	N
2. Scarlet fever?	Y	N
3. Heart defect? Heart murmur?	Y	N
4. Heart trouble? Angina? Heart attack?	Y	N
a. Do you have pain in your chest upon exertion?	Y	N
b. Are you ever short of breath after mild exercise?	Y	N
c. Do your ankles swell?	Y	N
d. Do you get short of breath when you lie down?	Y	N
5. Pacemaker?	Y	N
6. Heart surgery?	Y	N
7. High blood pressure?	Y	N
8. Low blood pressure?	Y	N
9. Hepatitis? Jaundice? Liver disease?	Y	N
10. Stroke?	Y	N
11. Sinus trouble?	Y	N
12. Lung or breathing problems?	Y	N
13. Asthma? Hay fever?	Y	N
14. Hives or skin rash?	Y	N
15. Fainting spells? Seizures?	Y	N
16. Diabetes?	Y	N
17. Cancer?	Y	N
18. Thyroid problems?	Y	N
19. Allergies?	Y	N
20. Arthritis? Rheumatism?	Y	N
21. Joint replacement? Implant?	Y	N
22. Stomach ulcer?	Y	N
23. Kidney trouble?	Y	N
24. Tuberculosis?	Y	N
25. Persistent cough?	Y	N
26. Cough that produces blood?	Y	N
27. AIDS or HIV infection?	Y	N
28. Sexually transmitted disease?	Y	N
29. Epilepsy?	Y	N
30. Anemia?	Y	N
31. Leukemia?	Y	N
32. Glaucoma?	Y	N
33. Acid reflux? Persistent heartburn?	Y	N

Do you have any disease, condition, or problem not listed above that you think we should know about? _____
If yes, Please explain: _____
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? _____
If yes, what antibiotic and dose? _____

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.

X _____
Signature of Patient, Parent, or Guardian Date

lisbon smiles
Ryan Nelson, DDS
420 Main Street, PO Box 1078, Lisbon, ND 58054
(701) 683-7695 (866)683-4654
www.lisbonsmiles.com

Name: _____ Date: _____

WHAT ASPECTS OF YOUR SMILE WOULD YOU LIKE TO IMPROVE?

____ CROWDING/CROOKED TEETH

____ SPACES

____ TOOTH SHAPE

____ TOOTH SIZE

____ GUMMY SMILE

____ UNDERBITE

____ TEETH ARE DIFFERENT COLORS

____ JAW JOINT PAIN

____ MISSING TEETH

____ DARK TEETH

____ SPEECH PROBLEMS

____ OVERBITE

____ FACIAL PROFILE

____ UGLY OLD CROWNS

____ OTHER _____

I AM INTERESTED IN:

____ SIX MONTH SMILES (Short-term orthodontic treatment)

____ INVISALIGN

____ TEETH WHITENING

____ PORCELAIN VENEERS

____ OTHER _____

IS THERE ANYTHING ELSE YOU WOULD LIKE DR. NELSON TO KNOW?_____
_____
_____
_____

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Financial Policy for Our Patients

Our office wants all of our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning your treatment. We proudly offer the following financial policy so that you can have the opportunity to decide which payment option best suits your needs:

Dental Insurance: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be asked to pay your deductible and your co-payment for the charges on the day the services are rendered. We are happy to file the forms necessary to assure you receive the full benefit of your dental insurance. We will gladly estimate your coverage; however, many variables exist from carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions). Therefore, we cannot guarantee any estimated charges. Because your insurance company has an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time.

Payment options:

1. Cash or check: We are happy to offer a 5% courtesy discount for all treatment over $500, paid in full in advance.
2. Credit Card: Our office accepts VISA, MasterCard, Discover and American Express.
3. Outside Financing:

   Care Credit – For treatment over $300, patients can apply while in our office and approval is known within a few minutes. Care Credit offers 6 or 12 month interest free plans and 24, 36 and 48 month extended payment plans with a 14.90% interest. There is no down payment required, no annual fees and no pre-payment penalty for this plan. If the interest free plans are not paid in the allotted time, the interest will be 26.99% and accrue from the first day.

   The Lending Club – For treatment over $499, patients can apply while in our office and approval is known within a few minutes. The Lending Club offers 6 or 12 months interest free plans and 24, 36, and 48 month extended payment plans with interest ranging from 3.99% - 24.99%. There is no down payment required, no annual fees and no pre-payment penalty for this plan. If the interest free plans are not paid in the allotted time, the interest will be 26.99% on the remaining balance. There's no retroactive interest.

Patient Name (printed)

Signature Date

Employee Signature Date

Effective date of notice: February 1, 2006

NOTICE OF PRIVACY PRACTICES

Lisbon Smiles
Ryan M. Nelson, D.D.S.
PO Box 1078
Lisbon, ND 58054
(701) 683-7695
fax: (701) 683-7698
lisbonsmiles@drtel.net

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

---------- tear here ----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Lisbon Smile's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

Our Mission Statement and Philosophy of Practice

Our goal is to provide the highest quality of dental care with exceptional service by going the extra mile before, during, and after treatment. We will thereby establish a lifelong partnership with our patients.

Our patients are the most important visitors on our premises. They are not dependent on us; we are dependent on them. They are not outsiders in our practice; they are part of it. We are not doing them a favor by seeing them; they are doing us a favor by giving us the opportunity to do so.

We shall strive for excellence with all of our patients. We shall set our goals to achieve total patient satisfaction with the highest quality treatment and exceptional service. We will leave each day proud that we did our best and provided state of the art technology to our patients.

This type of care can only be accomplished by a group of people that work well together and enjoy doing so. Selection of staff will be made using these criteria. The staff and the doctor will be kept up to date with the recent advances by continuing education.

Our office will be a place to visit and our patients will be made to feel at home. We want our patients to be proud to tell others where they received their dental care.

lisbon smiles
Ryan Nelson, DDS