



Clever Family Dental

Patient Registration

Patient: _____
First Name Middle Initial Last Name Preferred Name

Sex: *Male Female* **Age:** _____ **DOB:** _____ **SSN:** _____

Street Address: _____
City State Zip

Contact Info: _____
Home Cell Work Email

Marital Status: *Single Married Divorced Separated Widowed Student*

Spouse's Name: _____ **Parent's Name(s):** _____
(Required if under 18yrs. old)

Spouse's Work or Cell #: _____ **Parent's Work or Cell #:** _____

Other Emergency Contact: _____
Name Phone Number

Employment Status: *Full Time Part Time Retired* **Occupation:** _____

Employer: _____

Employer Address: _____

Preferred Pharmacy: _____

Relationship to Patient?: *Self Spouse Parent/Legal Guardian Other*
If not "self," please fill out the following responsible party information:

Insurance Information

Name of Primary Dental Insurance Company: _____

Dental Insurance Phone Number: _____

Name of Policy Holder: _____ **Policy Holder DOB:** _____

Policy Holder SSN: _____

Member ID: _____ **Group #:** _____

Policy Holder Employer: _____

Employer Address: _____
City State Zip

Whom may we thank for referring you to our office? _____

To the best of my knowledge, the questions on this form have been accurately answered. The above information relates to my billing and processing of insurance for benefits for which I am entitled. It is my responsibility to inform the dental office of any changes in my account and insurance information.

Signature of Patient or Parent/Guardian _____ **Date** _____

MEDICAL HISTORY FORM 2026

Patient Name:

Birth Date:

Date Created:

Are you currently under a physician's care; been recently hospitalized or had a head/neck injury? Yes No

Have you had any surgeries or major operations? If yes, please list dates and for what below: Yes No

Are you taking any medications, pills or drugs? If yes, please list below: Yes No

Do you take, or have you taken, blood thinners? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes

Women: Are you...

Pregnant

Nursing?

Taking oral contraceptives?

Trying to get pregnant

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfa Drugs

Local Anesthetics

Other? Yes No

Do you have, or have you had, any of the following?

- AIDS/HIV Positive Yes No
Alzheimer's Disease Yes No
Drug Addiction Yes No
Oral Herpes/Canker Sores Yes No
Rheumatism Yes No
Artificial Heart Valve Yes No
Hypoglycemia Yes No
Sinus Trouble Yes No
Blood Transfusion Yes No
Frequent Headaches Yes No
Cancer Yes No
Chemotherapy Yes No
Osteoporosis Yes No
Tumors or Growths Yes No
Ulcers Yes No
Autistic Yes No

- Cortisone Medicine Yes No
Diabetic Type 1 Yes No
Hepatitis B or C Yes No
Rheumatic Fever Yes No
Arthritis/Gout Yes No
Excessive Bleeding Yes No
Sickle Cell Disease Yes No
Blood Disease Yes No
Leukemia Yes No
Liver Disease Yes No
Glaucoma Yes No
Mitral Valve Prolapse Yes No
Tuberculosis Yes No
Congenital Heart Disorder Yes No
Convulsions Yes No

- Hemophilia Yes No
Hepatitis A Yes No
Renal Dialysis Yes No
Angina Yes No
Epilepsy or Seizures Yes No
Shingles Yes No
Fainting Spells/Dizziness Yes No
Kidney Problems Yes No
Stomach/Intestinal Disease Yes No
Stroke Yes No
Lung Disease Yes No
Tonsillitis Yes No
Cold Sores/Fever Blisters Yes No
Heart Pacemaker Yes No
Heart Trouble/Disease Yes No

- Radiation Treatments Yes No
Diabetic Type 2 Yes No
Dry Mouth Yes No
High Blood Pressure Yes No
Scarlet Fever Yes No
Artificial Joint Yes No
Irregular Heartbeat Yes No
Spina Bifida Yes No
Breathing Problems Yes No
Low Blood Pressure Yes No
Thyroid Disease Yes No
Heart Attack/Failure Yes No
Pain in Jaw Joints Yes No
Parathyroid Disease Yes No
Psychiatric Care Yes No

Have you ever had any serious illness not listed above? If yes, please list below: Yes No

As required by law, our office adheres to policies and procedures to protect your information we create, receive, or maintain. Your answers are for our records and will be kept confidential subject to applicable laws. You will be asked some questions about this questionnaire and concerning your health. This information is vital to allow us to provide appropriate care for you. By signing below, you certify that you have read and understand the above and that the information given is accurate. You will not hold this practice responsible for any action taken or not taken because of errors or omissions that may have been made on this form.

Signature of Patient, Parent or Guardian:

Date:

X



Clever Family Dental

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been reserved for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that time. If you need to cancel, reschedule, or miss an appointment, please know that calling on the weekend is not advised as it is outside the office hours and your message will not be received until the next business day.

If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. If a patient misses or cancels within the 48 hour notice, more than 2 appointments, they will be unable to reschedule. This is not to say that an appointment can't be made. The patient will have to be scheduled on the day they call for a same day appointment. Additionally, if a patient is more than 10 minutes late without prior notice, we will consider this a missed appointment and the same policy applies. **A \$25 failed appointment fee will be applied to all missed appointments or appointments cancelled same-day.**

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by these terms. I also understand and agree that such terms may be amended from time-to-time by the practice. I have received a copy of the Clever Family Dental Cancellation policy and agree to the terms stated therein.

Print Patient Name

Patient/Guardian Signature

Date



Clever Family Dental

PAYMENT AND INSURANCE DISCLAIMER

- Payment for services are due at the time treatment is provided. Every effort will be made to provide a treatment plan that fits your timetable, budget, and gives you the best possible care.
- We are excited to offer Cherry and Carecredit as alternate financing options for larger treatment plans. Both of these have 0% interest options available.
- Insurance is submitted as a courtesy for our patients. Every effort is made to estimate patient copay to the best of our ability. However, please understand this is never a guarantee of payment from your insurance company and you are ultimately responsible for payment in full if insurance does not cover your treatment. **We strongly advise you to be familiar with your insurance plan as this is a contract between you and them.**
- We will submit charges for dental work to your insurance company as long as we have received all needed information on the day of your appointment. We will collect payment from you based on the estimated amount your insurance is not estimated to pay on the day of treatment.
- You are responsible for any balance on your account after 90 days, whether insurance has paid or not. Depending on what you prefer, we will gladly send you a refund or leave the credit on your account for future treatment once we receive the payment from the insurance company.

I, _____ have read and understand the about statement regarding the insurance and payment policy for Clever Family Dental.

Signature: _____ Date: _____

Relationship to Patient: _____



Clever Family Dental

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used but not mandatory for me to sign in order to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by this office of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of this office's Privacy Practices or been made available, prior to signing this consent. I understand that this organization has the right to change its Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that this organization is not required to agree to my requested restrictions, but if this organization does agree, then said organization is bound by such restrictions.

I, hereby understand that I may revoke this consent in writing at any time except to the extent this organization may have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____



Clever Family Dental

HIPAA Authorization and Patient Financial Policy

Are there other people with whom we may share information regarding your dental care and billing information (Example: Husband, Wife, Significant Other, Friend, Parents, ect..)? Please list their names below:

Name: _____
Phone: _____

Relationship: _____
Dental Financial Both

Name: _____
Phone: _____

Relationship: _____
Dental Financial Both

Name: _____
Phone: _____

Relationship: _____
Dental Financial Both

By providing my signature below, I authorize communication with the above listed parties.

Patient or Responsible Party Signature

Date

NOTICE OF PRIVACY PRACTICES

Clever Family Dental

Effective Date: February 2, 2026

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Telephone: 417-583-2624

6809 State Hwy 14, Suite D, Clever, MO 65631

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic, and procedural safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against such risks such as loss, destruction and misuse.

USE AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on the dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- Healthcare quality assessment and improvement activities;
- Reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- Conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and
- Business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of these communications at any time.

Family, Friends, and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care, or payment for your health care. We will disclose the medical information that is relevant to the person's involvement. We may use or disclose your name, location and general location and general condition to notify, or to assist an appropriate public or private agency to locate and notify a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief effort.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgement to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email and telephone. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). If you prefer that we do NOT leave a message to confirm treatment or your appointments, please Initial here. _____

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

- For public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
- To avert a serious and imminent threat to health or safety;
- For health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
- For research
- In response to court and administrative orders and other lawful process;
- To law enforcement officials with regard to crime victims and criminal activities;
- To coroners, medical examiners, funeral directors and organ procurement organizations;
- To the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- 1) HIV/AIDS
- 2) Mental health;
- 3) Genetic Tests (in accordance with GINA 2009);
- 4) Alcohol and drug abuse;
- 5) Sexually transmitted diseases and reproductive health information; and
- 6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

- 1) You have a right to see and get a copy of your health records.
- 2) You have a right to amend your health information.
- 3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
- 4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.
- 5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or

disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile. If you would like to opt out of this level of service, you may do so by initialing here _____.

- 6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
- 7) You have a right to restrict who receives your information.
- 8) You have a right to request an amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
- 9) If you believe your rights are being denied or your health information is not being protected, you can:
 - a. File complaint with your provider or health insurer
 - b. File a complaint with the U.S. Government
- 10) You have the right to opt out of fundraising activities. If you would like to opt out of any fundraising programs that our office may participate in, such as community fundraisers, cancer walks, or other fundraising programs, you may do so by initialing here _____.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicated with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint. You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office of Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.