



**Smile Magic of Houston**  
6902 Southwest Fwy, Houston, TX 77074  
(281) 656-1011  
mysmilemagic.com/HOUSTON

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## NEW PATIENT FORM

### Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	

### Contact Information

### Address Information

Mobile phone:		Street address:	
Home phone:		City:	
Email:		State:	
		ZIP:	

### Basic Information

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## Welcome

**We would like to welcome you to our practice. Our practice is based on preventive care and our goal is to make your visit**

**pleasant and comfortable. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime!**

## Tell us about you:

Ethnicity/Race	
Preferred Language	

### Contact Information

I want you to contact me at this fax number	
May we text you?	
Leave messages on my answering machine or voicemail	
Leave messages with any other person.	

### CONFIDENTIAL & EMERGENCY CONTACT INFORMATION

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## CONFIDENTIAL & EMERGENCY CONTACT INFORMATION

Please list the family members(or other persons), if any, with whom we may discuss dental treatment and /or diagnosis and release records	
Contact 1 Phone Number	
Give Contact Consent for:	
Contact 2	
Contact 2 Phone Number	
Give Contact Consent for:	
Contact 3	
Contact 3 Phone Number	
Give Contact Consent for:	

05/23/2025

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### How did you Hear About Us?

HOW DID YOU HEAR ABOUT US?	
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Patient's signature:

Date:



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# CONSENT FOR DENTAL TREATMENT



I do hereby request and authorize **Smile Magic of Houston** and their staff to examine, clean, and provide dental treatment. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat dental problems. I will allow photographs to be taken of my teeth for diagnostic or educational purposes. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform **Smile Magic of Houston** of any changes in my medical status.

Patient's signature:

Date:



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## Smile Magic of Houston

### HIPAA Notice of Privacy Practices

**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.**

#### I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of [Smile Magic of Houston](#)

#### II. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and controls your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

#### III. Last Revision Date

This Notice was last revised on January 2022.

## **IV. How We May Use or Disclose Your Health Information**

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

### **A. Common Uses and Disclosures**

- 1. Treatment.** We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other healthcare professionals involved in your care.
- 2. Payment.** We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.
- 3. Health Care Operations.** We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and healthcare professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.
- 4. Appointment Reminders.** We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text, or email.
- 5. Treatment Alternatives and Health-Related Benefits and Services.** We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.
- 6. Disclosure to Family Members and Friends.** We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.
- 7. Disclosure to Business Associates.** We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, 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.

### **B. Less Common Uses and Disclosures**

- 1. Disclosures Required by Law.** We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

**2. Public Health Activities.** We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls, and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**3. Victims of Abuse, Neglect, or Domestic Violence.** We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect, or domestic violence.

**4. Health Oversight Activities.** We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

**5. Lawsuits and Legal Actions.** We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful processes that are not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

**6. Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for law enforcement purposes, such as to identify or locate a suspect, material witness, or missing person or to alert law enforcement of a crime.

**7. Coroners, Medical Examiners, and Funeral Directors.** We may disclose your health information to a coroner, medical examiner, or funeral director to allow them to carry out their duties.

**8. Organ, Eye, and Tissue Donation.** We may use or disclose your health information to organ procurement organizations or others that obtain, bank, or transplant cadaveric organs, eyes, or tissue for donation and transplant.

**9. Research Purposes.** We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

**10. Serious Threat to Health or Safety.** We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

**11. Specialized Government Functions.** We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

**12. Workers' Compensation.** We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illnesses.

## **V. Your Written Authorization for Any Other Use or Disclosure of Your Health Information**

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If the use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

## **VI. Your Rights with Respect to Your Health Information**

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

### **A. Right to Access and Review**

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in the format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or another format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

### **B. Right to Amend**

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

### **C. Right to Restrict Use and Disclosure**

You may request that we restrict the use of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

### **D. Right to Confidential Communications, Alternative Means, and Locations**

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

## **E. Right to an Accounting of Disclosures**

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, and health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

## **F. Right to a Paper Copy of this Notice**

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

## **G. Right to Receive Notification of a Security Breach**

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information. The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

## **VII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information**

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol, and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

## **VIII. Our Right to Change Our Privacy Practices and This Notice**

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you upon request. The effective date of this Notice is 01/01/2017.

## **X. How to Make Privacy Complaints**



If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint

Patient's signature:

Date:



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## CONTRACTED DENTISTS

Patient's signature:

Date:



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# FINANCIAL POLICY



We welcome you and your family to **Smile Magic of Houston**. We look forward to providing you with top notch quality dental care at affordable prices. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep informed and involved with your treatment as much as possible.

You need to be aware that:

- We will always do our best to help you to maximize your benefits.
- Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.
- Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

- Our staff is trained to help you with questions you may have relating to how your claim was filed, or regarding any additional information your carrier may need to process your claim. Please, ask if you have any questions
- As a courtesy to all of our insured patients, we will file your dental insurance claim forms. In special circumstances, a particular insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately, and benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any other amounts your insurance company chooses not to pay for whatever reason.

Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail. I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction.

I agree to pay for all treatment in a timely fashion as described.

## **Refund Policy**

All payments collected on date of service may be refunded same day. Refunds requested after date of service will be processed within 15 days of refund submission form. Please note ALL PENDING INSURANCE CLAIMS must be paid by your insurance company before a refund may be made.

[For patients with dental insurance who would prefer their insurance Company send payment to the office]

I hereby authorize my insurance benefits to be paid directly to **Smile Magic of Houston**. I realize that I am responsible to pay for any deductible amount(s), my co insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance, and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient's signature:

Date:



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## APPOINTMENT POLICY



# Appointment Policy

We are grateful for the opportunity to provide you with the Care, Comfort, and convenience you deserve. In doing so we understand that circumstances may arise that you may have to cancel or reschedule your appointment. During those times we want to ensure that we are understanding and accommodating. **Smile Magic of Houston** requires a 24 hour notice of cancellation at minimum.

By providing us with the proper notice, we are able to accommodate another patient that may be in need.

**What is a “no show”:** A “no show” occurs when a patient fails to keep their scheduled appointment or arrives 10 minutes late to their visit. Patients who “**No-Show**” a total of **3 times** within a **12-month period** may not no longer be allowed to reschedule and will only be able to see their provider on a **walk-in only basis**. If you cannot make your scheduled appointment please contact our office at least 24 hours in advance, by phone, text, or email. For Cash and PPO patients A **“No show” fee of \$25.00 will be issued for any failed appointments without a 24-hour notice.**

### Medicaid/CHIP Patients:

Medicaid is notified through our automated system whenever there is a cancellation or no-show. In order to keep your insurance active, you must follow your insurance company’s policy.

### Treatment Appointments

We truly value your time and make great efforts to stay on schedule. Please note that a small deposit will be collected upon the booking of your treatment appointment. Your prepaid deposit will be credited to your account and deducted from your final total.

**Monday through Saturday appointments**, \$25 is collected at the time you schedule your next appointment.

Patient's signature:

Date:

If you have any questions, please contact our office at (281) 656-1011



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# INSURANCE FILING AUTHORIZATION

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or the dental practice contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with all claims associated with the recipients on my insurance plan.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above dental entity.

Patient's signature:

Date: