Welcome

Thank you for selecting our dental healthcare team! 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.

Patient Information

Today's Date_____

Name_____ Social Security #_____ Date of Birth _____ Sex____

Address_____ City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail_____

Check appropriate box: Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Other [ ]

Referred to our office by_____

Responsible Party Information

Name of Responsible Party (guardian)_____ Social Security #_____

Address (if different than patient)_____ City, State, Zip_____

Occupation_____ Employer_____

Employer's Address_____ Phone_____

How would you like to pay for your portion of the provided services? Cash [ ] Check [ ] Credit Card [ ] Other [ ]

Responsible Party's Spouse

Name of Responsible Party's Spouse_____ Social Security#_____

Address (if different than patient)_____ City, State, Zip_____

Occupation_____ Employer_____

Employer's Address_____ Phone_____

Dental Insurance Information

Insurance Company_____ Insured Name_____

Insured DOB_____ Relationship to Patient_____

Subscriber #_____ Group #_____ Employer_____

Insurance Co. Address_____ Phone_____

Secondary Dental Insurance Information

Insurance Company_____ Insured Name_____

Insured DOB_____ Relationship to Patient_____

Subscriber #_____ Group #_____ Employer_____

Insurance Co. Address_____ Phone_____

Patient Medical History

General Health: Good [ ] Fair [ ] Poor [ ]

Physician_____ Office Phone_____ Date of Last Exam_____

Are you currently on any prescription or over the counter medications, vitamins, nutritional or herbal supplements? Yes [ ] No [ ]
if **"Yes"** please list medications and purpose:

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes [ ] No [ ] if **"Yes"** please circle or list

Penicillin Codeine Latex Local Anesthetics Sulfa Drugs Barbiturates Sedatives Iodine Aspirin Any Metals

_____ _____

Please mark the ones that apply to you and your Medical History.

[ ] Need antibiotic coverage prior to dental work?

[ ] Artificial joint replacement or Implant?

[ ] Undergone Radiation or IV Chemotherapy?

[ ] Use or have used tobacco products?

[ ] Subject to prolonged bleeding?

[ ] Family history of Diabetes?

[ ] Excessive thirst and/or urination?

[ ] Recent unusual weight loss?

[ ] Subject to fainting?

[ ] Recently hospitalized or past major surgeries?

[ ] (**Women**) Currently pregnant?____ How far?_____

[ ] (**Women**) Currently nursing?____

Please circle Y ***or*** N ***individually for each question:***

Y	N	High or Low Blood Pressure	Y	N	Heart Disease	Y	N	Osteoporosis
Y	N	Heart Attack	Y	N	Cardiac Pace Maker	Y	N	Chest Pains
Y	N	Rheumatic Fever	Y	N	Heart Murmur	Y	N	Long-Term Steroid Treatment
Y	N	Swollen Ankles	Y	N	Artificial Heart Valves	Y	N	Scarlet Fever
Y	N	Fainting / Seizures	Y	N	Frequently Tired	Y	N	Tuberculosis
Y	N	Asthma	Y	N	Anemia	Y	N	Glaucoma
Y	N	Epilepsy / Convulsions	Y	N	Emphysema	Y	N	Liver Disease
Y	N	Leukemia	Y	N	Cancer (type:_____)	Y	N	Hemophilia
Y	N	Diabetes (type:____)(A1C____)	Y	N	Arthritis / Rheumatism	Y	N	Respiratory Problems
Y	N	Kidney Disease	Y	N	Jaundice / Hepatitis (type:____)	Y	N	Mitral Valve Prolapse
Y	N	AIDS / HIV Infection	Y	N	Sexually Transmitted Disease	Y	N	Eating Disorders
Y	N	Thyroid Problem	Y	N	Stomach Troubles / Ulcers	Y	N	Neck or Back Problems

Do you have any other medical or health condition which is not listed? Yes [ ] No [ ] if **"Yes"** please list:

_____

Signature:_____ Date:_____ Staff_____

(For Office Use Only)

Notes & Updates: _____ Updated:_____ Pt..____ Staff_____

_____ Updated:_____ Pt..____ Staff_____

_____ Updated:_____ Pt..____ Staff_____

Emergency Contact

Name of Relative or Person NOT LIVING with you_____Relationship to you_____

Phone_____Address_____

Dental History

Name of Previous Dentist;_____Last Dental Visit?_____ Reason for today's visit?_____

Have you ever had a serious problem associated with a previous dental treatment? Yes [ ] No [ ]

If "**Yes**" explain_____

How often do you brush?_____How often do you floss?_____How often do you get cleanings?_____

What dental aids do you use? Floss [ ] Toothpick [ ] Water Pick [ ] Electric / Sonicare Toothbrush [ ] Other _____[ ]

Please answer Yes [ ] ***or*** No [ ].

Are you hesitant to come to the Dentist?	Yes [ ]	No [ ]	Do you snore or have trouble sleeping?	Yes [ ]	No [ ]
Do your gums bleed during brushing or flossing?	Yes [ ]	No [ ]	Would you like to have a whiter and brighter smile?	Yes [ ]	No [ ]
Do you have a bad taste or odor in your mouth?	Yes [ ]	No [ ]	Would you like to have straighter teeth?	Yes [ ]	No [ ]
Does food frequently get caught between your teeth?	Yes [ ]	No [ ]	Do you have missing teeth that you want replaced?	Yes [ ]	No [ ]
Do you have dental fillings that you don't like?	Yes [ ]	No [ ]	Do you have loose dentures or partials?	Yes [ ]	No [ ]
Do you believe in the benefits of fluoride?	Yes [ ]	No [ ]	Are you wearing away your teeth?	Yes [ ]	No [ ]

What do you **NOT** like about your smile?_____

What can we do to make your smile look better?_____

Consent for Treatment

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize Roselle Park Dental to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Responsibility for Payment: In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection sums due and unpaid for the work herein set forth.

Signature:_____ Date:_____

Children or Minors

Because (name of child)_____is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment

Signature:_____ Date:_____

Authorization for Signature on File

Release of Information/ Financial Responsibility/ Authorization for Payment

I (name of patient)_____ and/or (name of insured) _____ hereby authorize ***Roselle Park Dental*** to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with (name of employer)_____. I herby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

Signature of Patient (parent or guardian if minor) :_____

Signature of Insured:_____ Today's Date: _____

This "Authorization" will be valid from this date and shall expire in one year. Expiration Date: _____

A photocopy of this document may act as an original.

Office Policy

Please Read and sign at the bottom, acknowledging that you were informed of these policies. Let us know if you have any questions about our Office Policies. Thank you.

Financial Policy

Thank you for choosing ***Roselle Park Dental*** to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

- On your first visit we expect you to supply our office with your insurance information and photo ID card. It any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

- New patients are required to pay for services in full on their first visit. If the patient is a member of an HMO/DMO plan then the co-payment is due. Patients are required to pay their deductible and co-payments are at the time of each visit.

- While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.

- As a courtesy, we will gladly bill your insurance when you provide us with the current information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you either pay your portion of the bill at the time of service, or that a suitable written financial agreement be reached at the time of service. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account until it is paid in full. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. Please be aware that some, and perhaps all of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.

- If no payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that ***"This will be the final notice for payment"***. If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.

- Financial options are available to all patients. Please feel free to ask one of our office personnel.

Failed or Cancelled Appointments

If an appointment has been reserved for you, we kindly ask that patients give us twenty-four hours notice for cancellations; otherwise, we reserve the right to charge a minimum of $30.00 per half hour, which is currently our broken appointment fee. If the appointment is with a specialist, the minimum fee is $50.00 per half hour visits. The length of time reserved and the number of prior failed appointments determines your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice.

Estimates and Fees

After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. There is a service charge on all unpaid accounts.

Delinquent Accounts

Delinquent accounts will have to be turned over to a Credit Reporting Collection Agency.

Notice of Privacy Practices (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations. Of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.

Signature:_____ Date:_____

HEAD HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

Please review and answer all parts of each question with our staff. Provide specific details/notes in the righthand column.

#	QUESTIONS		ANSWERS		NOTES - LIST QUESTION #, THEN DESCRIBE SYMPTOM DETAILS
1	Have you noticed a change in your bite? » Do you feel like your teeth hit first on the right or left side? ☐ RIGHT ☐ LEFT » Do you hit more on the front teeth or more on the back teeth? ☐ FRONT ☐ BACK		☐ YES	☐ NO	
2	Are you aware of any of the following:	Popping/Clicking	☐ YES	☐ NO	
		Grinding	☐ YES	☐ NO	
		Noise in the Jaw Joints	☐ YES	☐ NO	
3	Do you have difficulty or pain ☐ opening wide ☐ chewing?		☐ YES	☐ NO	
4	When you wake up, do your jaw joint or muscles feel tight or sore?		☐ YES	☐ NO	
5	Do you snore at night?		☐ YES	☐ NO	
6	Does your jaw joint or muscles feel stiff, tight or tired after eating?		☐ YES	☐ NO	
7	Do you grind or clench your teeth ☐ at night ☐ during the day?		☐ YES	☐ NO	
8	Do your gums bleed after ☐ brushing ☐ flossing?		☐ YES	☐ NO	
9	Do you experience pain in your:	Jaw	☐ YES	☐ NO	
		Face	☐ YES	☐ NO	
		Neck	☐ YES	☐ NO	
		Shoulder and/or Arms	☐ YES	☐ NO	
10	Do you get ☐ headaches ☐ migraines? » If Yes, what time of day do they occur? ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ ANYTIME » How many headaches (H) and migraines (M) each week? _____ (H) /_____ (M) Each month? _____ (H) /_____ (M) » What medications do you take to relieve them? _____ » How long do they last without medications? _____		☐ YES	☐ NO	
11	Do you have any ☐ ringing ☐ fullness in your ears?		☐ YES	☐ NO	
12	Do you ever get ☐ dizzy ☐ sea sick?		☐ YES	☐ NO	
13	Do you ever feel ☐ anxiety ☐ stressed? » How would you rate your stress level? ☐ MILD ☐ MODERATE ☐ SEVERE		☐ YES	☐ NO	
14	Have you had braces or orthodontic treatment? » If Yes, when did you finish your treatment? _____		☐ YES	☐ NO	
15	Have you ever worn a ☐ bite splint ☐ retainer? » If Yes, when did you have this treatment? _____		☐ YES	☐ NO	
16	Have you ever had a ☐ car accident ☐ trauma to your head? » If Yes, describe and list dates: _____		☐ YES	☐ NO	
17	Have you ever had any sports injuries? » If Yes, describe and list dates: _____		☐ YES	☐ NO	
18	Do you restrict or avoid normal activities due to pain or symptoms? » If Yes, describe activities: _____		☐ YES	☐ NO	
19	Do you spend 4+ hours working at a desk or using a computer daily?		☐ YES	☐ NO	

Scoring: 1-3 "Yes" Responses = Mild unbalanced bite | 4-6 "Yes" Responses = Moderate unbalanced bite | 7+ "Yes" Responses = Severe unbalanced bite

When finished, please return to our office and review your answers with our staff.