

PATIENT INFORMATION

Patient's Name: (Last) _____ (First) _____ (MI) _____
Address: (Street/Apt.) _____ (City) _____ (St) _____ (Zip) _____
SS#: _____ Birth Date: _____ Sex: _____ Marital Status: Minor() Single () Married ()
Phone No: (H) _____ (W) _____ Separated () Divorced () Widowed ()
Additional Phone/Cell No: _____ Student? _____ Full-time () Part-time ()
Spouse/Parent's Name: _____ Email: _____
Are any of your family members our patients? (Yes/No) _____ If Yes, Who? _____
How did you hear about us? _____
Previous Dentist's Name and Phone No.: _____
Last Dental Visit (Date): _____

PRIMARY DENTAL INSURANCE

Name of Insurance Co.: _____ Phone No.: _____
Subscriber's Name: _____ Date of birth _____ Relationship: _____
Employer's Name: _____ SS No./ID No.: _____
Employer's Address: _____ Group No.: _____

SECONDARY DENTAL INSURANCE

Name of Insurance Co.: _____ Phone No.: _____
Subscriber's Name: _____ Date of birth _____ Relationship: _____
Employer's Name: _____ SS No./ID No.: _____
Employer's Address: _____ Group No.: _____

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Physician's Name: _____ Phone No.: _____

YES **NO**

_____ Are you having any pain or discomfort at this time?
_____ Have you ever had a full mouth x-rays taken of your teeth? If yes, when? _____
_____ Have you ever had treatments for your gums?
_____ Do your gums hurt or bleed when you brush?
_____ Do your teeth hurt when you chew?
_____ Have you ever had orthodontic treatment or worn braces?
_____ Have you ever been aware of a bad odor or taste in your mouth?
_____ Are your teeth sensitive to hot, cold or sweet?
_____ Do you clench or grind your teeth during day or night?
_____ Do you ever wake up from sleep due to shortness of breath?

Are you on a special diet?
 Do you use a tobacco products? What and how much _____
 Do you use alcoholic beverages? How much _____ How often _____
 Have you been a patient in the hospital during past two years? For what _____
 Have you been under the care of a medical doctor during last past years? For what _____

FOR WOMEN ONLY

Are you now or think you may be pregnant?
 Are you nursing?
 Are you presently taking birth control pills?

Are you taking any other medicine, drug or pills?

If yes, please list _____

Are you allergic or have your reacted adversely to any of the following medications?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Percodan	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Darvon	<input type="checkbox"/> Scopolamine	<input type="checkbox"/> Valium	
<input type="checkbox"/> Demerol	<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Sleeping Pills	
<input type="checkbox"/> Other, list _____			

Check any of the following you have had or have at present:

<input type="checkbox"/> AIDS (HIV)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Fainting or Dizzy Spells	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Cancer or Tumors	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Stroke
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Cough	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Herpes	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Liver Disease	<input type="checkbox"/>

List any other condition not listed above: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill of services. I agree to be responsible for payments for all services rendered on my behalf or my dependents.

X _____ Date: _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DENTAL OFFICE INFORMED CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is a risk associated with dental procedures, and all your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like "filling" can lead to major complications that cannot be foreseen. For example, "Novacaine" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments. The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I have read, understand and consent to dental treatments. INITIALS: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are required to pay for services as rendered. We accept cash, Visa, MasterCard, American Express and Discover or Debit/ATM cards. We offer an in-house customized Membership Plan. We offer 5% courtesy on the prepayment of *Patient-Doctor discussed treatment* plans. We offer up to 12 months interest free financing plans.

OFFICE POLICY

When you make an appointment we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. **We reserve the right to charge for any appointment(s) broken without a 48 hours notice. The charge will be \$50.00 for every thirty minutes of appointment time. Checks returned from the bank is subject to \$ 35.00 service fee.**

Accounts delinquent more than 60 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

We welcome you to our office and want to provide you with the best dental care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED CONSENT AND FINANCIAL POLICIES.

Signature: _____ Date: _____

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. We agree in writing with every patient to sign our financial policy, as we have found with our past experience that this policy makes our mutual experience easier and without confusion. This policy is to ensure that all of our patients receive a highest level of quality dental care in a friendly and healthy environment while understanding their financial responsibilities. This policy as well as other health and insurance forms provided must be read, agreed to, and signed prior to any dental treatment.

Cash Patients

Patients with no insurance are expected to pay in cash, check or credit card the day the service is rendered, unless specific arrangements are made in advance.

Insurance Patients

For those patients covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% of the cost of your treatment. In this day and age many cover 50% or less on many services and actually cover nothing on others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a pre-determination to their insurance carriers. We state what treatment you need, and they tell us what they will cover on that treatment plan. Many patients prefer to get service started immediately, and some treatments should be started immediately. In these cases we will ask you to pay for your services in full as they are done, and when the insurance company pays their portion we will reimburse you for what they pay. We will assist you in dealing with the insurance company, but ultimately the responsibility of payment and insurance problems lies with you. If we do accept assignment of benefits from the insurance company, if the insurance company hasn't paid after 45 days, the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. Thank you for reading and understanding our financial policy. If you have any questions or concerns; please feel free to ask them at any time. We wish to be of assistance in any way we can.

Sincerely,

Dr. _____

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED FINANCIAL POLICIES.

Signature of responsible party

Date: _____

Please print your name

❖ WE OFFER DENTAL WARRANTY ON CERTAIN DENTAL TREATMENT. PLEASE ASK DOCTORS FOR DETAILS.

END