Welcome

ABOUT YOU

Today's Date: ____/____/____ File #:____

Patient Name: ______________________
LAST FIRST MI

What You Prefer To Be Called: ____________ ❑ Male ❑ Female

Birthdate:___/___/___ Age:_____ SS#:__________

Mailing Address:______________________

CITY STATE ZIP

Home Phone #: (_____)__________

Work Phone #: (_____)__________ Ext:_____

Cell Phone #: (_____)__________

E-mail Address:______________________

Referred By: ______________________

Employer:______________How Long?______

Employer's Address:______________________

CITY STATE ZIP

Occupation: ______________________

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ______________________

Do you have children? ❑ Yes ❑ No How many? ______

INSURANCE INFO

Primary Dental Insurance

Co. Name: ______________________

Address:______________________

CITY STATE ZIP

Phone #: (_____) __________

Insured's ID#:______________________

Group # (Plan, Local, or Policy #):______________

Insured's Name: ______________________

Relation:__________Date of Birth:___/___/___

Insured's Employer:______________________

Secondary Dental Insurance

Co. Name: ______________________

Address:______________________

CITY STATE ZIP

Phone #: (_____) __________

Insured's ID#:______________________

Group # (Plan, Local, or Policy #):______________

Insured's Name: ______________________

Relation:__________Date of Birth:___/___/___

Insured's Employer: ______________________

ACCOUNT INFO

Person ultimately responsible for account

Name:______________________

Relation: ______________________

Billing Address:______________________

CITY STATE ZIP

SS #: ______________________

Drivers License #: ______________________

Work Phone #: (_____)__________

Payment method: ❑ Cash ❑ Check

______________________ ___/___

❑ Credit Card - Enter card # above V-CODE_____

______ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company

IN EVENT OF EMERGENCY

Whom should we contact?______________________

Relation: ______________________

Home Phone #: (_____)__________

Work Phone #: (_____)__________

Cell Phone #: (_____)__________

Who is your Medical Doctor?______________________

Medical Doctor's Phone #: (_____)__________

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long?______________________

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: ____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ______________________________ (____) __________
Name Phone#

Last Dental exam: _____/_____/_____ Last Dental X-rays: _____/_____/_____

Times a day you brush? __________ Times a week you floss? __________

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers (including aspirin)** ❑ **Muscle relaxers** ❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**

❑ **Other(s), please list:** ____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: ______________________

____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ Foods: ____________________ ❑ Others: ____________________

Do you use tobacco? ❑ No ❑ Yes/How used? ____________ How much? ______ How long? _____

Please rate your general health from 1-10: ____________ Do you wear contact lenses? ❑ Yes ❑ No

- ◆ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- ◆ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________________ Date ____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ____ Date __/__/__
Comments

Initials ____ Date __/__/__
Comments

Initials ____ Date __/__/__
Comments

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Name of Patient: ______________________________

Section B: To the Patient-please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Vanessa Todd - Office Manager at (562) 923-4538

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, **I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.**

______________________________ ______________________________

Signature of Patient or Responsible Party Date Print Name of Patient or Responsible Party:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

ONLY SIGN BELOW IF YOU WISH TO REVOKE YOUR CONSENT

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted in the reasons area below. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Revocation of consent: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ____________________

Reason for revocation:

____

____

____

Dental X-rays Avoiding Overexposure

Asking a dentist to work without x-rays, one says, is like asking an auto mechanic to find what's wrong with your engine without lifting the hood. X-rays provide a valuable way to detect and track dental disease

One source of unnecessary exposure: switching dentists. Generally, when you visit a new dentist, he or she will want to take a FMX, full-mouth series of images, a baseline from which to spot changes. Since a full-mouth series need be done only every 3 to 5 years, try to arrange for your previous dentist to send recent x-rays or duplicates.

Modern equipment, 'faster' film, and the lead apron used in dental offices all limit a patient's exposure to x-rays. The American dental association estimates that a full mouth series done with modern equipment exposes a patient to thirteen millirems of radiation. For comparison, the average person receives 300 millirems a year from natural environment, such as standing in front of your microwave, television and being exposed to sunlight, and workers whose occupation involves radiation are permitted 5000 millirems of whole body exposure a year.

We here at Dr. Duncker's we strongly suggest that new patients receive a current full-mouth set of x-rays or at minimum provide a recent set taken by a former dentist. After the initial exam each patient is individually assessed for the appropriate period between check-up x-rays. So remember when it comes to dentistry avoiding overexposure is important, but must be balanced with the calculated conservative recommendation of our trained dental team.

I understand the above information is necessary to provide me with dental care in a safe efficient manner.

Patient's Signature:**X**____________________________________ Date:____________

MISSED APPOINTMENT FEE:

Your Dental plan contract specifies that a fee must be charged for failing to show for a regularly scheduled appointment. Our office policy is a $40.00 charge for each 30 minutes scheduled in our appointment book.

This policy specifies that if you do not give our office a 24-hour notice in advance of the appointment, your account will automatically be charged $40.00.

We are informing you that we cannot give credit, due to the fact that your plan is giving you a discount from the doctor's REGULAR FEE. You must pay for each visit, meaning each treatment.

I understand the above information and my signature below acknowledges my financial responsibility for any missed appointment. I hereby understand the above and agree to pay the services.

Signature:**X**____________________________________ Date:____________

DENTAL FINANCIAL POLICY FOR PATIENTS WITH DENTAL INSURANCE

The following financial policy applies to all patients who have insurance coverage. Please carefully read and sign this agreement providing you agree with it. Let our finance staff know if you have any questions.

1.) **Insurance billing:**

We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, please remember that paying for your dental care is your personal responsibility. We will bill your insurance company every two weeks. Payment from them is expected within 60 days. We will automatically transfer and bill you for any payments not received from your insurance company after 60 days. You will need to pay us in full at that time. Any amounts you personally owe that are 30 days late will receive a service charge of 1 ½ % per month.

2.) **Co-pays:**

Unless, prior financial arrangements are made between you and the financial coordinator, you will need to pay for your portion of the charges as you go. This includes the annual deductible, co-payment, and charges your insurance company refuses to pay.

3.)**Verifying insurance:**

We will need to verify your insurance benefits by contacting the insurance company. We will also have you sign other forms as needed.

PLEASE NOTE: Until we have verified your coverage, you will be responsible for paying for your own care at each visit including the first visit. After we verify your coverage, we will credit the amount you have paid to your portion of the bill.

4.) **Insurance payments and/or information:**

Occasionally an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important.

Your insurance company may request additional information from you. Please send the information to them right away. They will not pay your claim until they receive the information.

5.) **Insurance termination:**

If you suspend or terminate your insurance coverage, please advise the front office staff before your appointment date. If you do not notify us and the insurance does not pay, the services given will be payable by you. Also, if you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by you or your insurance company will become immediately due and payable by you personally before you leave.

By signing below you agree to this policy.

Signature: ____________________ Date: Print Name: ____________________