

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 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

DIRECT PAYMENT FOR PATIENTS WITHOUT DENTAL INSURANCE

The following financial policy applies to all patients who will be paying for their own care. Please carefully read and sign this agreement providing you agree with it. Let our finance staff know if you have any questions.

You can choose between three different methods of payment.

1.) PAY IN ADVANCE:

Pay in full for your treatment program and receive a 10% discount on the total amount. Collecting money owed from insurance companies or patients takes a considerable amount of time and expense. We have found it easier and less expensive when patients pay in advance. We can then pass the savings on to you. You can pay with a check, Visa, MasterCard, Discover, or American Express.

2.) PAY AS YOU GO:

Pay for each individual service before receiving the treatment and receive a 5% discount.

3.) ARRANGE FINANCING WITH CARE CREDIT OR UNICORN FINANCIAL:

These plans are like a dental credit card. If you are approved, then through a special arrangement with care credit and unicorn financial, you may pay for your treatment plan with no interest plans up to 12 months or low monthly APR payments for up to 60 months.

We are very happy you chose us for your dental care. We will do all we can to help you achieve optimum dental health care. Please let us know of any way we can better serve you.

By signing below you agree to this policy.

Print name:

Date:

Signature:

Finance Staff:

Date: