Mark J. Panneton, DDS
Casey L. Sexton, DDS

How did you hear about us?_____ Today's Date_____

Patient Information

Last Name:_____ First Name:_____ Middle Initial: ____

Address:_____ City:_____ ST:___ Zip:_____

We Confirm appointments via emails and text messages when possible. Please CIRCLE the best option.

Mobile Phone:_____ Email Address:_____

Home Phone:_____ Work Phone:_____ Employer:_____

Sex: M F Marital Status:_____ Birth Date:_____ Social Security #:_____

Driver's License #:_____ State Issued:___ Medical Doctor:_____

Emergency Contact Name:_____ Emergency Contact Number:_____

Responsible Party (If patient is under 19)

Last Name:_____ First Name:_____ Middle Initial: _____

Address:_____ City:_____ ST: ___ Zip:_____

Social Security #:_____ Date of Birth:_____ Relation to Patient:_____

Home Phone:_____ Work Phone: _____ Mobile Phone:_____

Primary Dental Insurance Information: Verified ☐

Company Name:_____ Policy Number:_____

Name of Insured:_____ Relationship to Insured:_____

Employer of Insured:_____ Group Number:_____

Policy Holder's Social Security #:_____ Policy Holder's Date of Birth:_____

Policy Holder Number (if applicable): _____

Secondary Dental Insurance Information Verified ☐

Company Name:_____ Policy Number:_____

Name of Insured:_____ Relationship to Insured:_____

Employer of Insured:_____ Group Number:_____

Policy Holder's Social Security #:_____ Policy Holder's Date of Birth:_____

Policy Holder Number (if applicable): _____

Medical Insurance Information:

Company Name:_____ Policy Number:_____

Name of Insured:_____ Relationship to Insured:_____

Employer of Insured:_____ Group Number:_____

Policy Holder's Social Security #:_____ Policy Holder's Date of Birth:_____

Policy Holder Number (if applicable): _____

Patient Name_____

Dental History Questionnaire

Dates of last dental visit_____ Last dental Cleaning_____ Last dental x-rays_____

Previous dentist name _____How often do you have a dental examination?_____

Restorative Dentistry

Do you have dental problems or concerns?_____If yes, please describe the problem_____

_____

Do you have existing crowns (caps)? When were they placed?_____

Do you have any missing teeth? When were they removed?_____

Orthodontics

Have you ever had orthodontics?_____Were you pleased with the result?_____

Would you like to learn more about what orthodontic options are available?_____

Whitening

Have you ever whitened your teeth?_____ Were you pleased with the result?_____

Would you like to learn more about whitening options? _____

Periodontal Disease

Do you have trouble with bad breath?_____ Do you have any loose teeth?_____

Have you ever been treated for periodontal disease?_____

Sleep Apnea

Have you ever been diagnosed with sleep apnea?_____Are you currently being treated?_____

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in constrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to rate the following situations.

0=would never doze. 1=slight chance of dozing. 2=moderate chance of dozing. 3=high chance of dozing.

Sitting and reading_____Watching TV_____

Sitting, inactive, in a public place (theater, meeting)_____

As a passenger in a car for an hour without a break_____

Lying down to rest in the afternoon when circumstances permit_____

Sitting and talking to someone_____

Sitting quietly after lunch without alcohol_____

In a car, while stopped for a few minutes in traffic_____ Total:_____

Patient Name_____

Financial Options

Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology.

METHODS OF PAYMENT

Your portion is due date of service.

1. Cash, check, or credit card (MasterCard, Visa, American Express or Discover)
2. Dental Insurance (described below)
3. Application available for third party financing.

DENTAL INSURANCE

1. Our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the Assignment of Benefits form. **Our computer system will estimate your portion based on the information you have provided us and expected coverage. We ask that your estimated co-payment and deductible be paid at the time of service.** Please let us know if you would prefer to pay your balance in full and have your insurance company pay you directly.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

RELATED INFORMATION

1. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month or 18% annual. Returned checks will be assessed additional fees and will be turned over to the county attorney's office for collection if not paid timely.
2. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs, and collection agency fees).
3. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. 24-hour notice is needed to avoid a charge.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Patient or Parent/Guardian:_____ Date:_____

Insurance Assignment

I certify that the insurance information I have provided is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and me.

Patient Name_____

I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand that my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

I hereby instruct and direct my insurance companies to pay Mark J. Panneton, DDS, PC directly for the dental benefits allowable and otherwise payable to me under my current insurance policy. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A scanned copy of this Assignment shall be considered as effective and valid as the original. I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I hereby appoint Dr. Panneton to act on my behalf as my representative to appeal any decisions made by the insurance company. I also request and authorize Dr. Panneton to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

Signature of Patient or parent/guardian Date

Consent: I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs, or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Office Agreements: I agree to follow the doctor's directives ***precisely*** and ***completely*** throughout my course of therapy. Following directions ***exactly*** ensures optimal care and maximizes my potential for improved health. I agree to keep regularly scheduled appointments as directed by the doctor in order to maintain continuity of care. I agree to pay for services rendered as outlined in the financial options agreement. I agree to conform to acceptable, peaceful behavior during my course of therapy at this office. I agree to be honest and forthright with all interactions and communications and have not misrepresented myself in patient registration information and health history matters. A breach of any of these agreements terminates the doctor/patient relationship as defined by this document.

_____ _____

Signature of Patient or parent/guardian Date

MINOR/CHILD CONSENT

I, being the parent or guardian of_____do hereby request and
Name of minor/child

authorize the dental staff to perform necessary dental services for my child, including but not limited to radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate, and administration of anesthetics, which are deemed advisable by the doctor.

SIGNATURE_____DATE_____