

Welcome to Elite Dental, LLC

Please provide us with your **Driver's License/Photo ID & Insurance card**

Part 1

Patient Name: _____ Male Female
Last Name First Name M.I.

Home Address: _____
Street City State Zip Code

I prefer to be called: _____ Birth Date: ____/____/____ SSN: ____-____-____
Month Day Year (Social security Number)

Phone (Home): ____-____-____ (Work): ____-____-____ Ext: ____ (Cell): ____-____-____
E-Mail _____ Single Married Divorced Child Domestic Partner

Employer _____ Position: _____ Unemployed Self-employed Retired

Best time to call: _____ Best way to contact me: Home Phone Cell Work Email Other _____

Preferred appointment times: AM PM Other _____

Emergency Contact (name) _____ Phone: ____-____-____ Relationship to Patient _____

How did you find out about us? _____

Do you have any family members that come to Elite Dental? _____ Who? _____

For Dependents age 18 and over with insurance :

Are you a student? Yes No Full-time Part-time Name of School: _____

School Address: _____ Phone: ____-____-____
Street City State Zip Code

Person Responsible for Account (If other than yourself)

Part 2

Responsible Party Name: _____ Birth Date: ____/____/____ SSN: ____-____-____
Last Name First Name M.I. Month Day Year (Social security Number)

Relationship to Patient: _____ E-Mail _____

Phone (Home): ____-____-____ (Work): ____-____-____ Ext: ____ (Cell): ____-____-____

Home Address: _____
Street City State Zip Code

Place of Employment/ Employer _____

Employer Address: _____
Street City State Zip Code

Dental History

Part 3

Reason for today's visit? Check-up (Exam & X-rays) Cleaning Consultation for _____
 Emergency (in pain) How long have you been in pain? _____

Previous Dentist _____ City/State _____ Date of last dental visit? _____

When was the last time you had? Exam _____ Full-mouth X-rays _____ Cleaning _____

How many times a week do you floss? _____ How many times a day do you brush? _____

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? Yes No

OVER →

HEALTH HISTORY

Doctor's Name: _____ Phone: _____ - _____ - _____ Date of last exam : _____

Do you have, or have you ever had any of the following?

Heart Attack / Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer / Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy / Seizure / Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur / Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes / Tuberculosis (TB)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug / Alcohol Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV+ / AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Surgery / Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia / Abnormal Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Congenital Heart Defect	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia/ Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High / Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma / Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Developmental Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema / Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hospitalization (for: _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>For Women:</u>			Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking birth control pills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Severe / Frequent Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant? (Week# _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		
Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tobacco/Smoker (Frequency _____)		

ALLERGIES

Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tetracycline	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dental Anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Erythromycin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Percodan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other _____			Demerol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Valium	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Sulfa	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Iodine	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEDICATIONS

(List any medications including asthma inhalers or nitroglycerin even if only used 1 or 2 times a year)

Name Of Medication	Strength (mg or ml)	Taken How Often?	What Is Drug Taken For?

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. **I understand that all payments are due at the time of my visit including Co-Payments.**

Signature _____
Patient (if over 18) or Parent/Legal Guardian

Date: ____/____/____
Month Day Year

Elite Dental, LLC

Acknowledgement of Privacy Practices

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

- Provide and coordinate my treatment among the number of healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand the my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy 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: _____
Patient (if over 18) / Parent / Legal Guardian

Date: ____/____/____
Month Day Year

Authorization for Signature on File & Payment Release of Information/Financial Responsibility

I _____ understand and agree that I am responsible for all charges incurred
Name of Patient (if over 18) / Parent/ Legal Guardian

regardless of insurance coverage. I understand that Elite Dental, LLC have accepted the insurance company's verification of coverage and benefits in good faith that the claim will actually be covered as described by the insurance company. In the event that the insurance company does not cover the claim for verified benefits, I agree to be responsible for all charges for dental services and materials which I and/or my dependents have incurred and authorized in my treatment and/or my dependent's treatment. I agree that any balance not paid by my insurance company within 30 days will be my responsibility to pay. I agree to furnish the insurance company and Elite Dental, LLC with any additional information or paperwork requested to expedite payment of my claim. To the extent permitted under applicable law, I hereby authorize release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I hereby assign and authorize payment of dental benefits otherwise payable to me, directly to the office of Elite Dental, LLC. I agree that a photocopy of this document & authorization may act as an original and that my signature below shall authorize payment to the Elite Dental, LLC/the dentist for any services rendered to me or my dependents as if I had signed each benefit assignment on future claims. Furthermore, it is agreed and understood that any past due **balance older than 60 days will be subject to a late charge of \$50**. In addition, I will be responsible for any costs associated with my account being placed under collection including but not limited to collection costs, attorney's fees. Also, a \$30 fee will be charged for returned checks.

Signature: _____
Patient (if over 18) / Parent / Legal Guardian

Date: ____/____/____
Month Day Year

Elite Dental, LLC

**Failure to Keep Appointment Policy
"No Show"**

Appointments made at our office are reserved exclusively for you. If you need to change your appointment, we would appreciate the courtesy of being informed at least 24 hours in advance. This allows another patient to take your reserved time.

We understand that on occasion cancellations are necessary, particularly due to illness. Please remember that each appointment time is reserved exclusively for that individual patient, and without adequate time to fill the broken appointment, the operatory is empty for that time. Unfortunately, the overhead of the operatory continues. Therefore, if we are unable to have at least 24 hours notice of a cancellation, an overhead **\$50 charge** will be made for "No Show" appointments. We would much prefer never to make that charge, so try to schedule a time most convenient for you. Appointments will be considered a "No Show Appointment" if you are **more than 30 minutes late** for your scheduled time and will be charged \$50.

This will be billed directly to you and will not be covered by your insurance. Signing this form indicates you understand the charge and that payment is your responsibility. There is a 24-hour notice to cancel your appointments to avoid this charge.

Frequent failure to keep scheduled appointments confirms to us that the patient/office relationship is not working. After multiple such events, the office will no longer see the patient.

Signature: _____
Patient (if over 18) / Parent / Legal Guardian

Date: ____/____/____
Month Day Year