Big Horn
DENTAL CLINIC

Patient Name: _____
Last *First* *MI* *Preferred name*

Date of Birth: _____ Age: _____ Social Security #: _____ Sex: M F

Mailing Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Occupation: _____ Patient Employer/School: _____

Married Widowed Single Minor Separated Divorced Partnered for _____years

Spouse's Name: _____ Date of Birth:_____
Last *First* *MI*

Social Security #: _____ Phone #: _____

Spouse's Employer: _____ Work #: _____

Responsible Party Name: _____ Relationship to Patient: _____

Social Security #: _____ Date of Birth: _____

Insurance Information:

Insurance Company:_____ Policyholder Name:_____

Policyholder Employer:_____ ID#:_____ Group#:_____

Policyholder Date of Birth:_____ Policyholder SSN:_____

IN CASE OF EMERGENCY, CONTACT *(specify someone who does not live in your household)*

Name:_____ Relationship:_____

Home Phone:_____ Work Phone: _____

Physician Name:_____ Preferred Pharmacy:_____

Reason for today's visit:

_____

Date of last dental visit _____ **Date of last dental x-rays** _____

How often do you floss? _____How often do you brush?_____

Women: *Taking Birth Control?* Yes No *Are you pregnant?* Yes No Due Date_____ *Are You Nursing?* Yes No

Dental Health History

Food Collection between teeth	Yes No	Fingernail biting	Yes No	Bad Breath	Yes No
Bleeding Gums	Yes No	Foreign objects	Yes No	Grinding teeth	Yes No
Blisters on lips or mouth	Yes No	Gums swollen or tender	Yes No	Jaw pain or tiredness	Yes No
Burning sensation on tongue	Yes No	Lip or cheek biting	Yes No	Loose teeth	Yes No
Chew on one side of mouth	Yes No	Broken or missing filling	Yes No	Mouth breathing	Yes No
Cigarette, pipe, cigar smoking	Yes No	Orthodontic treatment	Yes No	Pain around ear	Yes No
Sores/ Growth in mouth	Yes No	Sensitivity to cold	Yes No	Sensitivity to heat	Yes No
Periodontal treatment	Yes No	Sensitivity when biting	Yes No	Mouth Pain Brushing	Yes No
Sensitivity to sweets	Yes No	Dry Mouth	Yes No	Clicking or popping jaw	Yes No

Health History

AIDS/HIV	Yes No	Emphysema	Yes No	Physical Challenges	Yes No
Anemia	Yes No	Epilepsy	Yes No	Radiation Therapy	Yes No
Arthritis	Yes No	Glaucoma	Yes No	Respiratory Disease	Yes No
Artificial Joints	Yes No	Headaches	Yes No	Rheumatic Fever	Yes No
Asthma	Yes No	Heart Murmur	Yes No	Scarlet Fever	Yes No
Back Problems	Yes No	Heart Problems	Yes No	Shortness of Breath	Yes No
Bleeding abnormally	Yes No	Hepatitis Type____	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Herpes	Yes No	Skin Rash	Yes No
Cancer	Yes No	High Blood Pressure	Yes No	Special Diet	Yes No
Chemical Dependency	Yes No	Jaundice	Yes No	Stroke	Yes No
Chemotherapy	Yes No	Kidney Disease	Yes No	Swollen Feet/ Ankles	Yes No
Circulatory Problems	Yes No	Liver Disease	Yes No	Swollen Neck Glands	Yes No
Cold Sores	Yes No	Low Blood Pressure	Yes No	Thyroid Problems	Yes No
Congenital Heart Lesions	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Cortisone Treatments	Yes No	Psychiatric Care	Yes No	Tuberculosis	Yes No
Cough persistent/bloody	Yes No	Nervous Problems	Yes No	Ulcer	Yes No
Diabetes	Yes No	Pacemaker	Yes No	Unexplained Weight Loss	Yes No

Medications: List any medications you are currently taking and the correlating conditions:_____

_____

Allergies : Aspirin Amoxicillin Barbiturates Cephalexin Clindamycin Codeine Demerol Erythromycin Dental Anesthetics Ibuprofen Iodine Latex NSAIDS Niacin Penicillin Preservatives Sulfa Sunscreen/PABA Tetracycline Tylenol Other:_____ ☐ No Known Drug Allergies

Dental 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 with 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 physicians' certifications.

I acknowledge that I have received your Notice of Dental 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 Dental Privacy Practice from time to time and that I may contact this organization at any time at the address to obtain a current copy of the Notice of Dental 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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then are bound to abide by such restrictions.

By Signing I have read the above Notice of Dental Privacy Practices Acknowledgement and agree to its contents.

Patient Name (PRINT) :_____

Last First MI

Signature: _____ Date: _____

Relationship to patient: _____

TURN PAGE OVER

Financial Agreement

The following information is to inform you of our financial policy. If at any time you have questions regarding this policy, please do not hesitate to ask any member of the business team. We recommend you contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage.

We are committed to providing you with the highest quality of care. Our fees reflect the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, Discover, and American Express. We have partnered with Care Credit, a third-party company, to offer the flexibility of deferred interest and extended payment options.

Check Policy: If your check is returned for any reason, a $30.00 NSF fee, any applicable postage, and legal fees are subject to be applied to your account.

Treatment Cost Estimates: The team at Big Horn Dental Clinic will communicate all recommended treatment options and associated fees prior to the start of treatment. The fee amounts provided are subject to change and should be treated as an estimate. As a courtesy to our patients with dental insurance, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require all applicable deductibles and the estimated patient portion be paid at the time service is rendered.

Assignment of Benefits: We do accept assignment of insurance benefits as a form of payment to reduce the impact of an immediate out-of-pocket expense. Your dental insurance company may also provide payments to you directly. In this instance, we ask that insurance payments are provided to Big Horn Dental Clinic within *30 days* of receipt. Our office has extended a courtesy to you by allowing you to bring in your insurance payments at a later date; the account balance after insurance payments remains your responsibility. If for any reason an insurance payment is not turned in to Big Horn Dental Clinic, you understand you are responsible for the account balance.

Past Due Balances: A delinquent account impedes our ability to provide you with the quality dental care you deserve. Accounts that are over 90 days past due will be turned over to an external collection agency, and a 40% collection fee will be added to your account.

Cancellation Policy: We are committed to respecting your time and ask that you make every effort to keep the appointment time we reserved exclusively for you. We understand there may be times you are unable to keep your scheduled appointment, however, any missed or cancelled appointment may be subject to a $59.00 fee. Should you need to reschedule or cancel an appointment, we require 2 business days' notice; failure to provide notice within the required time frame will result in a cancellation fee.

Assignment and Release: By signing this document, I agree that Big Horn Dental Clinic and its representatives may use my healthcare information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment and determining insurance benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____

Witness: _____ Date: _____