Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name ____________________ ____________________ __________ Soc. Sec. # ____________________
Last Name *First Name* *Initial*

Address ____________________

City ____________________ State ________ Zip ________ Home Phone ____________________

Cell Phone ____________________ Email ____________________

Sex ❑ M ❑ F Age __________ Birthdate __________ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by ____________________ Occupation ____________________

Business Address ____________________ Business Phone ____________________

Business Email ____________________

Whom may we thank for referring you? ____________________

Notify in case of emergency ____________________ Home Phone ____________________

Cell Phone ____________________ Business Phone ____________________

Email ____________________

Primary Insurance

Person Responsible for Account ____________________ ____________________ __________
Last Name *First Name* *Initial*

Relation to Patient ____________________ Birthdate ____________________ Soc. Sec. # ____________________

Address (if different from patient) ____________________ Home Phone ____________________

City ____________________ State __________ Zip ____________________

Cell Phone ____________________ Email ____________________

Person Responsible Employed by ____________________ Occupation ____________________

Business Address ____________________ Business Phone ____________________

Business Email ____________________

Insurance Company ____________________ Phone ____________________

Insurance Mailing Address ____________________

Contract # ____________________ Group # ____________________ Subscriber # ____________________

Name of other dependents under this plan ____________________

Pharmacy Name ____________________ Phone ____________________

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ____________________ Relation to Patient ____________________ Birthdate ____________________

Address (if different from patient) ____________________ Soc. Sec. # ____________________

City ____________________ State ________ Zip ________ Home Phone ____________________

Cell Phone ____________________ Email ____________________

Subscriber Employed by ____________________ Business Phone ____________________

Business Email ____________________

Insurance Company ____________________ Phone ____________________

Insurance Mailing Address ____________________

Contract # ____________________ Group # ____________________ Subscriber # ____________________

Name of other dependents under this plan ____________________

Please complete both sides.

Dental History

What would you like us to do today? ________ Are you in dental discomfort today? ________

Former Dentist ________ Address ________

Dentist's Email ________ Phone ________

Date of last dental care ________ Date of last x-rays ________

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? ________ Floss? ________

How do you feel about the appearance of your teeth? ________

Do you wish your teeth were straighter? ❑ Y ❑ N

Do you wish your teeth were whiter? ❑ Y ❑ N

Are you unhappy with any fillings, crowns or bridges? ❑ Y ❑ N

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment ________

Medical History

Physician's name ________ Phone ________

Date of last visit ________ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe ________

Are you currently under physician care? ❑ Y ❑ N If yes, describe ________

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates ________

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Do you smoke or use other tobacco/smokeless products? ❑ Y ❑ N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other ____

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe ________
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

____

____

Does patient have drug allergies? If yes, list all:

____

____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ________ Date ________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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NOTICE OF PRIVACY PRACTICES (HIPAA)

** THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION **

Dear Patient:

Our Promise

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA-Health Insurance Portability & Accountability Act)
We will use and communicate your Health Information only for the purposes of providing your treatment, obtaining payment, conducting health care operations and as otherwise described in this notice.
Federal law generally permits us to make certain uses or disclosures of health information without permission. Federal law also requires us to list in the notice each of these categories of uses or disclosures.

As Required by Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in the court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are victim of abuse, neglect or domestic violence (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to work only with companies with a similar commitment to the security of your health information.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your **treatment, medications, transportation, or payment**. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care. If this form is being filled out for your child, this includes anyone who would be bringing them to or picking them up from their appointments.

Please list the name(s) of the person (people) we may discuss treatment and the account with:

____________________________ ____________________________

____________________________ ____________________________

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mail communications that are sealed. We will honor your reasonable requests for confidential communications.

Can we leave a message on cell phone or home phone? (Please circle answer):

Yes **No** **Initials** __________.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail you a copy.

Changes to this Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice.

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form below.

__________________________________ ____________
Patient Signature (parent *or* guardian if under 18 years of age) **Date (mm/dd/yyyy)**

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Office Policy

Dear Patient,

We have prepared this letter to help you better understand the complexities of dental insurance, as we realize how confusing it can be. To begin, we would like to highlight the misconception that dental insurance was designed to pay for all dental care. Unfortunately, that is not the case. It is simply a benefit to assist in making treatment more affordable. Most contracts have limits and/or various degrees of co-payments including deductibles that are the patient's responsibility.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, time, and our constant dedication to provide our patients with the most advanced techniques and highest quality of dental care. Your treatment should not be governed by your insurance contract/company.

It should be understood, however, that the dental insurance contract is between the insurance company and the patient, who ultimately bears the financial responsibility.

*** Please note, that all co-payments and/or deductibles are due at the time of service ***

We hope this information has been helpful. Please take time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask us for clarification of services, billing and insurance.

We do require 24-48 hours notice if you cannot make it to your reserved appointment as there may be a patient in pain who can utilize this appointment. By giving us this advance notice, it allows us to fill this spot or have it available for a pending emergency.

** **If 2 appointments are missed without 24-48 hours' notice, we will not be able to schedule another appointment.** **

** **If you are more than 15 minutes late to any appointment, we will have to reschedule. After 2 offenses, we will not be able to schedule another appointment.** **

Thank you for choosing our office for you and your family and thank you in advance for your understanding and cooperation regarding this policy. We truly appreciate you and all our patients and hope to make this experience the best it can be.

______________________________ ______________

Patient Signature (parent *or* guardian if under 18 years of age) **Date (mm/dd/yyyy)**