Patient Information (Printed)

Patient's Name: ____ ☐
Last First Middle
Preferred Name: ______________________________ Male/Female Birthdate: ____/___/_____ Age: ______
Address: ____
Street City State Zip
Home Phone: _______________ Cell Phone: ___________________ **Email:** ____________________________
Patient's Social Security #: ______________ Driver License # and State: _________________________________
Marital Status: Single Married Divorced Other
Name of primary physician: ___________________________________ Phone #: ____________________________
Name of previous dentist: ________________________________ Phone #: ____________________________
Date of last dental visit: __________________

Whom may we thank for referring you to our office? ___________________________

Insurance Information

Primary Insurance Information:
Subscriber's Name: ____ Subscriber's Birthdate: ____/___/_____
Subscriber's Social Security #: ____________________________ Subscriber's ID#: ____________________________
Subscriber's Employer: __________________________________ Group/Plan #: ______________________________
Insurance Company Name: ________________________________ Insurance Company Phone #: _________________
Insurance Company Address: ____
Street City State Zip
Do you have secondary insurance coverage? Yes No
Secondary Insurance Information:
Subscriber's Name: ____ Subscriber's Birthdate: ____/___/_____
Subscriber's Social Security #: ____________________________ Subscriber's ID#: ____________________________
Subscriber's Employer: __________________________________ Group/Plan #: ______________________________
Insurance Company Name: ________________________________ Insurance Company Phone #: _________________
Insurance Company Address: ____

Emergency Contact Information

Name: ____
Phone #: _______________________________________ Relationship to Patient: ___________________________

OVER

Health History Information

Previous Dentist: ____ Date of Last Dental Visit: _________________
Reason for this visit: ____

Have you ever had any of the following? Please check all that apply:

- ☐ AIDS
- ☐ Allergies _________ ____________________ ____________________
- ☐ Anemia
- ☐ Arthritis
- ☐ **Artificial Joints**
- ☐ **Artificial / Leaky Heart Valve**
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cold Sores/ Fever Blisters
- ☐ Special Needs
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ ADHD
- ☐ Diet: (Special / Restricted)
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ H.I.V Positive
- ☐ Head Injuries
- ☐ **Heart** (Attack, Disease, Surgery)
- ☐ **Heart Murmur**
- ☐ Autism
- ☐ Hepatitis
- ☐ **High Blood Pressure**
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ **Mitral Valve Prolapse**
- ☐ Nervous Disorders
- ☐ **Pacemaker**
- ☐ Psychiatric / Psychological Care
- ☐ **Pregnancy:** Due date: _______________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ **Rheumatic Fever**
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoke / Chew Tobacco
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Allergic / Adverse Reaction To Medication or Any Substance, Please Specify: _______________ ______________________ ____________________
- ☐ Do you Pre- Medicate with antibiotics prior to dental visits? ____**Yes** ____**No**

If any condition or alerts selected above needs further clarification, please explain below: ____________________
____

Name of Physician and their specialty: ____

Most recent physical exam and purpose: ____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment: ____

List all medications, supplements, and / or vitamins taken within the last two years: __________________________
____
____
____

The above information and all the proceeding answers, is true, accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail. I accept responsibility for payment of all dental services. I will not hold my dentist or any member responsible for any errors or omissions that I may have made in the completion of this form.

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Print Name of Patient　　Signature of Patient (or Parent/Guardian if under age 18)　　Date

COMPASS POINT DENTAL POLICIES/ARRANGEMENTS & ACKNOWLEDGMENTS

FINANCIAL POLICY AND INSURANCE

We accept cash, Visa, MasterCard, Discover, American Express and Care Credit! Care Credit is a private payment program we offer. For additional information please ask one of our team members. Our fees, when quoted for treatment, will be honored for 90 days. Beyond that, fees may be adjusted to reflect any cost increases.

Most insurance plans do not cover 100% of the treatment cost. Therefore, you will be expected to pay your deductible and your ESTIMATED co-payment prior to the day services are rendered. Many variables exist from carrier to carrier (ex. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges.

You are responsible for advising this office if you have any changes in your insurance coverage prior to your appointment. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Should the account become past due and be referred to a collection agency, the undersigned agrees to pay and all additional costs/fees and/or interest charged by, or as a result of the referral, to a collection agency, in addition, should the account be referred to an attorney for collections, the undersigned agrees to pay any and all attorney's costs/fees and/or interested charged as a result of the referral.

CANCELLATION POLICY

Patients are seen by reservation, emergencies and walk-ins will be seen as time permits. We respectfully ask that you give us 48 notice to reschedule your reservation. If you fail to do so, you will be subject to a $25.00 failed/less than 48 hour notice cancellation fee.

- Our office will attempt to confirm all appointments twice; If we are unable to reach you, we ask that you call back and confirm that you are keeping your appointment. **Should we not be able to confirm these appointments with you, we will be forced to forfeit the appointment to another patient on our waiting list.** You are responsible for informing our office of changes in your contact information.
- We reserve the right to dismiss patients with whom this becomes habitual, and is at our discretion.

OVER

PHOTO/VIDEO CONSENT

I give Compass Point Dental the right to use any photo/video for the exclusive purpose of marketing this practice and/or patient education.

PRIVACY PRACTICES

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 provider certifications.

I have been informed by your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above address 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 healthcare 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

SIGNATURE ON FILE

I hereby authorize payment directly to Compass Point Dental, of the dental benefits otherwise payable to me. Compass Point Dental, and it's providers, are authorized to provide any insurance company(s), claim administrator(s), and counseling health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

Print Name of Patient Signature of Patient (or Parent/Guardian if under age 18) Date