PATIENT NAME_____ **Date**_____

Primary reason for this dental appointment ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Date of last examination _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? If not Why? _____ Yes No
Does food catch between your teeth? If so where? _____ Yes No
Any sores or growths in your mouth? Discuss _____ Yes No
Do you smoke or chew? _____ Yes No
Name of previous dentist
Date of last full mouth x-rays (16 small films or panoramic)

Medical History

Are you under a physician's care now? Why? _____ Who?_____ Yes No
Have you ever been hospitalized or had a major operation? Discuss_____ Yes No
Are you taking any medications? Yes No Please List _____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures: please circle

Y N Heart Disease*
Y N High Blood Pressure
Y N Blood disorder – Anemia
Y N Rheumatic Fever
Y N Heart Murmur*
Y N Mitral Valve Prolapse*
Y N Pacemaker*

Y N Psychiatric Treatment
Y N Arthritis
Y N Tumor History/Cancer
Y N Venereal Disease (STD)
Y N Tuberculosis, Emphysema
Y N HIV Positive (Aids)
Y N Artificial Bones/Joints*

Y N Ulcers
Y N Hepatitis
Y N Alcohol or Drug Abuse
Y N Diabetes
Y N Thyroid Disease
Y N Stroke
Y N Fainting/Seizures/Epilepsy

Y N Cold Sores
Y N Cankers Sores
Y N Herpes
Y N Sinus Trouble

ALLERGIES
Y N Penicillin
Y N Other Antibiotics _____
Y N Aspirin
Y N Codeine
Y N Latex
Y N Local Anesthetic

***If yes to any of the starred conditions, please contact your physician**…..Pre-medication may be required….

Please list any other medical condition(s) you have or ever had: _____

For Women: Are you taking Birth Control pills? **Yes No** Are you Pregnant? **Yes No Maybe** Due Date? _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient. If you have any questions on coverage bring your benefits booklet and we will try and help you understand it.
- We give a 10% cash discount for complete payment at time of treatment.
- Our policy requires payment in full at time of visit unless other arrangements have been made. If account is not paid within 90 days of the date of service and no arrangements have been made you will be responsible for legal fees, collection fees, interest charges and any other expenses incurred in collecting your account.
- **Some insurances companies will pay for white fillings and others only pay the amount on white fillings that they would pay for silver fillings. Our office only does white fillings. It will be <u>your</u> responsibility to pay any cost difference.**
- Late cancellations or missed appointments can be charged $50.00.
- Balances unpaid after 60 days are charged interest of 1.5% monthly (18% annually).
- I have read or been offered the <u>Notice of Privacy Practices</u> required by HIPPA.

Signed_____ Date _____ Dentist: _____ Hygienist: _____

Welcome –Tell Us About You

Patient Information

Date_____

Name_____□ Married □ Single □ Minor □ Male □ Female

Address _____City_____Zip_____

Name you go by if different _____Social Security #_____**Birthdate**_____

Telephone _____

Home Work **Cell Phone** # **E-Mail**

If Full Time Student, School Name_____Grade_____

Person Responsible for Account – Check one: □ Patient □ Guardian □ Spouse □ Father □ Mother

INSURANCE INFORMATION

If you have Dual Coverage – Complete Primary and Secondary Insurance

Primary Insured/If No Insurance Complete for Responsible Party

_____

First Last

_____

Street City State & Zip

_____

BIRTHDATE (MONTH/DATE/YEAR) Relationship to Patient

_____

Employer Dental Insurance Company

_____

SS# OR ID# (FIND ON INSURANCE CARD) **GROUP #**

Secondary Insurance

_____

First Last

_____

Street City State & Zip

_____

BIRTHDATE Relationship to Patient

_____

Employer Dental Insurance Company

_____

SS# OR ID# (FIND ON INSURANCE CARD) **GROUP#**

IF YOU HAVE BEEN ON YOUR INSURANCE LESS THAN ONE YEAR LET US KNOW.

Person to Contact in Case of Emergency

Name_____

Address _____

City/State/Zip_____

Telephone #'s_____

Has any member of your family ever been treated in our office? Yes No

Whom may we thank for referring you to our office?

_____

Our office is happy to help you file your dental insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location, Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. Your Employee Benefits Director can usually help you become familiar with your plan and its' restrictions, and our office will assist you in maximizing your benefits. **We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental histories and other information about my dental treatment to third party payers.**

_____ _____

Patient or Insured **Date**

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we have you read and sign prior to any treatment.

REGUARDING PAYMENT

A 10% ADJUSTMENT WILL BE GIVEN FOR PAYMENT IN FULL (CASH OR CHECK) AT TIME OF SERVICE.

8% ADJUSTMENT WILL BE GIVEN AS ABOVE IF USING A CREDIT OR DEBIT CARD if you have no insurance.

Due to the high overhead costs of a dental practice 30% of total charges are required at the time of service if you have insurance. Without insurance, payment in full is expected the day of service.

We accept cash, checks, and the following credit cards: VISA, MasterCard, and Discover.

REGUARDING INSURANCE

Your insurance policy is a pre-determined arrangement between your employer and the insurance company. We are not a party to that contract. As a service to our patients we are happy to submit an insurance claim for you. Unfortunately insurance benefits **will almost always be less than anticipated**. Any quotes on payment are an estimate.

Please be aware that some of the services provided may be "non covered" services under your particular policy. We cannot be held responsible for the decision or the amount of payment from your insurance. It is your **responsibility** to contact your insurance company to determine your insurance company's benefits or requirements. We will try and help you as much as we can, but due to the many insurance policies available we have a very difficult time knowing each ones limits and restrictions.

We will work with your insurance company for 90 days. If your insurance company does not pay within 90 days, you will be responsible to pay your account.

Referral Disclosure: This facility may refer their patients to another dental facility if the services of that other dental facility are required to meet the needs of our patients. Referrals will always be made only to competent experienced dentists. Dentists to whom this facility refers patients may financially or otherwise compensate this facility. None of the compensations is charged to the patient. This facility is a member of, and thus interested in Dental Cooperative, a network of quality dentists. We may refer patients to the Dental Cooperative or another member of the Dental Cooperative.

In consideration for the professional services rendered to me or at my request for my minor child or ward by the dentist I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered or within (5) billing days if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, I writing, within the time for payment thereof. I further agree to pay all costs of collection including 40% collection fee, attorney fees and court costs. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc., to the dentist's collection agency or attorney should collections procedures as described become necessary.

I authorize the dentist to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that I have answered all questions accurately and to the best of my knowledge. I also have read or been offered a copy of this Facility's Notice of Privacy Practice (HIPPA). I here by abide by the conditions outlined here in.

Signature of Patient, Parent or Guardian_____ Date_____ Relationship to Patient_____