Patient Name: ____
(Last) (First) (MI)
Birth Date:____/_____/_____ Age:____**SS**:______________
Sex: ___Male ___Female
Status: ___Minor ___Single ___Married ___Separated
Mailing Address:_____________________________________
____
Home Phone:____
Work Phone:____
Cell Phone: ____
Emg Phone: ____
Email Address:______________________________________
How did you hear about us? __ ________________________
Employer:____
Employer Address:______________________________________

Primary Dental Insurance:
Insurance Name:_______________________________________
Phone#____
Insured's SS# ____
Group# ____
Insured's Name: _______________________________________
Relation:__________ Insured's Birth Date:___/___/______
Insured's Employer: ____________________________________

Secondary Dental Insurance:
Insurance Name:_______________________________________
Phone#____
Insured's SS# ____
Group# ____
Insured's Name: _______________________________________
Relation:__________ Insured's Birth Date:___/___/______
Insured's Employer: ____________________________________

Person ultimately responsible for account
Name:____
Relation:____
Billing Address (if different):___________________________
____
SS# ____
Driver License#_______________________________________
Work Phone#____

Physician's Name:_________________________________
Physician's Phone# _______________________________

Have you ever had any of the following diseases or medical problems? *(if you answered yes to any condition below, please strike off the one that doesn't apply)*

Y	N	Heart Attack/Stroke	Y	N	Psychiatric Problems
Y	N	Cancer/chemotherapy	Y	N	Epilepsy/Seizures/Fainting
Y	N	Heart Murmur	Y	N	Diabetes
Y	N	Tuberculosis(TB)	Y	N	Asthma
Y	N	Rheumatic Fever	Y	N	Drug/Alcohol Abuse
Y	N	HIV/AIDS	Y	N	Venereal Disease
Y	N	Heart Surgery/Pacemaker	Y	N	Ulcers/Colitis
Y	N	Hemophilia/Abnormal Bleeding	Y	N	Shingles
Y	N	Mitral Valve Prolapse	Y	N	Congenital Heart Defect
Y	N	Kidney problems	Y	N	Anemia/Radiation Txt
Y	N	Artificial Bones/joints	Y	N	Arthritis
Y	N	Artificial valves	Y	N	Difficulty breathing
Y	N	Sinus Problems	Y	N	Hospitalized for any reason
Y	N	High/Low Blood Pressure	Y	N	Hepatitis
Y	N	Fever Blisters	Y	N	Blood Transfusion
Y	N	Severe/Frequent Headaches	Y	N	Emphysema/Glaucoma

Please list any serious medical condition(s) that you ever had:

Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Codeine

Are you allergic to any other drugs? ___Yes ___No
If yes, please list:____________________________________

Are you presently taking any drugs prescribed by a physician or dentist? ___Yes ___No
If yes, please list:____________________________________

For Women:
Are you pregnant? ___Yes ___No, Wk# ______
Are you taking birth control pills? ___Y ___N

Do you need to be pre-medicated before dental treatment? ___Yes ___ No

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Dental History:
Y N Is there any dental problem that you are currently having?
If yes, please describe:____
Y N Have you ever had treatment for your gums?
Y N Do your gums bleed or hurt when you brush?
Y N Do your teeth hurt when you chew?
Y N Have ever been aware of a bad odor or taste in your mouth?
Y N Are you sensitive to hot or cold or sweets?
Y N Do you clench or grind your teeth during day or night?

(Please turn over) >>>

DENTAL OFFICE INFORMED CONSENT

It is very important to us that you, our patient, understand that the dental treatments and procedures are not to be taken for granted as being routine or without risk of complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body, there are potentially many variables, some predictable and others not. Complications rates in dentistry are low but they do exist. Even minor procedure such as "filling" can lead to major complication that can't be foreseen. For example, a "Novocain" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. These complications can be transient or may persist requiring further treatments.

The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, fractures and other nerve problems.

EMAIL / TEXT MESSAGES: Our office periodically sends emails and text messages for appointment reminders and other necessary communications.

FINANCIAL POLICY

1. PATIENTS WITH INSURANCE COVERAGE:

Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you, but ultimately it is patient's responsibility to understand their insurance benefits. Routine treatments are generally performed without submitting a request of pre-estimate of benefits. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to the treatment. If your insurance company denies the claim, the balance will be automatically transferred to you. In some cases, insurance carrier may pay for alternative benefits than the treatment performed. In this case you are responsible to pay for the difference. **All procedure involving lab work will require 50% down payment, then the remaining 50% balance will be due at the day of final insertion.**

2. PATIENTS WITHOUT INSURANCE COVERAGE:

Patients without insurance coverage are required to pay for services as rendered. We accept Cash, Check, MasterCard, Visa, Discover, American Express or Debit/ATM cards. We also offer patient financing plans.

3. ALL PATIENTS:

a. Unless other arrangements have been made in advance, all copay and deductibles **must be paid** at the time of service. You have to pay approximate payment towards the co-payment for today's dental treatments. Once the insurance claim is finalized, we will adjust the final balance. If you underpaid, you will receive a bill from us. If you overpaid, we may keep the credit balance towards your future treatment. It is your responsibility to request our office for a statement of accounts or a refund of your credit balance.

b. Checks returned unpaid from the bank are subject to $30.00 service fee.

d. **Accounts delinquent more than 60 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency, you will be responsible for collection fees which are $15 fee for 1st phase of collection and additional 50% of your balance for 2nd phase of collection, in addition to court costs and attorney's fees.**

BROKEN APPOINTMENT POLICY

When you make an appointment, we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We reserve the right to charge for any appointment(s) broken without 24 hours advance notice. The charge will be $35.00 for every thirty minutes of appointment time reserved.

I HAVE READ AND AGREE TO THE ABOVE DENTAL OFFICE INFORMED CONSENT, FINANCIAL POLICIES AND OFFICE POLICY CONCERNING SCHEDULING APPOINTMENTS.

X____ ________________

Signature of Patient/Parent/Guardian **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

Signature: ________________________________ Date:_______________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign. ☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (Please Specify)