**WELCOME**

Date\_\_\_/\_\_\_/\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First M.I.

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home# (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work# (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell# (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_/\_\_\_/\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_

 Child Single Married Divorced Widowed

Name of Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of College (if full time student) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best # to call (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you the patient’s parent/guardian? Yes No

Parent/Guardian DOB \_\_\_/\_\_\_/\_\_\_\_\_ Parent/Guardian SSN \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_

How did you learn about our office (please check all that apply):

□ Family Member □ Friend □ Dental Insurance □ Other Dental Office □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Name of Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Social Security# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Subscriber’s Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have secondary insurance?  Yes or  No

Name of Secondary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Social Security #\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Subscriber’s Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

 THERE HAS BEEN NO CHANGE TO MY DENTAL INSURANCE COVERAGE

**PATIENT MEDICAL HISTORY**

1. Are you in good health?  Yes or  No If no, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you under a physician’s care?  Yes or  No If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you taking any medications?  Yes or  No If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Please check any illnesses you have had or presently have:

□ ADD/ADHD □ Epilepsy □ High Blood Pressure □ Pacemaker

□ Artificial Joints □ HIV/AIDS □ Low Blood Pressure □ Psychiatric Care

□ Asthma □ Heart Disease □ Lung Conditions □ Rheumatic Fever

□ Autism □ Heart Valve □ Kidney Disease □ Stroke

□ Diabetes □ Hepatitis □ Liver Disease □ Tuberculosis

5. Do you have any conditions not listed above that you feel we should know about?  Yes or  No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Are you aware of any medication allergies?  Yes or  No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you have trouble with prolonged bleeding?  Yes or  No

8. Do you use tobacco products?  Yes or  No, What type(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*THIS SECTION - NEW PATIENTS ONLY\*\***

When was your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who was your previous dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DENTAL HISTORY**

1. Have you ever been treated for gum disease? Yes No

2. Are you pleased with the appearance of your teeth? Yes No

3. Are you in pain now? Yes No

4. Do your gums bleed? Yes No

5. Do your teeth feel loose? Yes No

6. Do you grind your teeth during the day or night? Yes No

7. Do you have sensitive teeth? Yes No

8. Have you received orthodontic treatment in the past? Yes No

9. Do you have any lumps or sores in or near your mouth? Yes No

**Authorization and Release**

I certify that I have read and understand the above to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination render to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Print Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 Patient or Guardian

**FINANCIAL ARRANGEMENTS, DENTAL INSURANCE, AND OFFICE POLICY**

 We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

 Payments for services are due at the time services are rendered. We accept cash, checks, MasterCard, Visa or Discover. There is also outside financing available, please ask for additional information. On initial visits, if we cannot verify your insurance coverage, you are responsible for the full fee at the time of service.

 I understand that if I do not pay in full or make reasonable payments on my balance within 30 days of the monthly billing, a late charge of 1.5% will be assessed each month. I realize that failure to keep this account current may result in your being unable to receive additional dental services except for dental emergencies or where there is prepayment for additional services. I agree to be responsible for any collection cost should collection action become necessary.

 Returned checks will be charged a $30.00 NSF fee and outstanding balances older than 30 days will accrue a finance charge. A charge of 55.00 may be made for all broken appointments cancelled without 48 hour notice.

**Please note:** As a courtesy to you, we will make every effort to remind you of your scheduled appointment. If our attempts are unsuccessful, it is still your responsibility to keep your scheduled appointment or contact us 48 hours in advance to change or cancel your appointment.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

**1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.**

**2. This is to notify those utilizing dental insurance for payment that if the balance of the amount is not paid within 30 days, you will be notified that you insurance company has not paid and we will require payment directly from you.**

**3. We will file the insurance payment as a courtesy, but it is not our responsibility to make certain whether or not they pay. This is your responsibility.**

**4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will cover. This is also your responsibility to know. We as your healthcare provider do what is in your best interest and not what your insurance plan dictates.**

**We must emphasize that as a dental care provider, our relationship is with YOU not the insurance company. While filing of the insurance is a courtesy to you, all charges are your responsibility from the date of services rendered.**

If you have any question about the information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are here to help.

Print Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_/\_\_\_\_\_

Relationship to Patient: Self Parent/Guardian Spouse

**PATIENT HIPAA CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

• Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

• Obtaining payment from third party payers (e.g. my insurance company);

• The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Are we permitted to leave a message? Yes No Best # to call (\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

Are we permitted to speak to another family member in regards to your care? Yes No

Family member’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: Parent/Guardian Spouse Friend Other \_\_\_\_\_\_\_\_\_\_\_

**CANCELLATION/MISSED APPOINTMENT POLICY**

 We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your oral health is something our office takes quite seriously. Because we care about you, we realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the policies we ask you to adhere to.

 We want to see you on time to have adequate time to do all the necessary procedures. Arriving on time will permit all the treatment planned for the day. Each time a patient misses an appointment without providing notification (no-shows), another patient is prevented from receiving care.

In an instance of a cancellation without 48 hour notice or no-show to a scheduled appointment, we reserve the right to charge you a $55.00 fee. In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care, allow care on a space available basis, or provide appointments on a pre-pay basis. The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient’s next appointment.

 We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Print Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Relationship to Patient: Self Parent/Guardian Spouse