



Patient Information

Patient's Name: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Social Security #: _____

Email Address: _____

Home Phone #: _____ Cell #: _____

Occupation: _____

Preferred contact by (check all that apply):

Home Phone Cell Phone Text Email

Gender: Male Female

Marital Status: Married Single Widowed Divorced

Who may we thank for referring you to our office?

Responsible Party Name: _____

Relationship to Patient: _____

Dental Insurance Information

Name of Policy Holder: _____

Relationship to Patient: Self Spouse Child Other

Policy Holder SS# or Alternate ID#: _____

Policy Holder Date of Birth _____

Name of Insurance Co: _____

Policy Holder Employer: _____

Insurance Phone# _____

Dental History

Date of your last dental cleaning: _____

Date of your last dental x-rays: _____

Do you have serious dental anxiety? Yes No

Your primary reason for coming in today is:

Have you ever had any of the following?

Periodontal (Gum) Disease..... Yes No

Have you received any treatment?..... Yes No

Loose teeth..... Yes No

TMJ (Jaw Joint) Problems..... Yes No

Frequent chipped or broken teeth or restorations..... Yes No

- Excessive wear..... Yes No
- Missing teeth that you want replaced..... Yes No
- Do you wear a nightguard or TMJ Splint..... Yes No
- Do you like your smile?..... Yes No
- If No, would you like to talk about changing your smile? Yes No
- Would you like to have your teeth bleached?..... Yes No
- Would you like to have your teeth straightened?..... Yes No
- Overall goal for your dental health:
-

Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

- Are you taking any medications, pills, or drugs?..... Yes No
- If yes _____
- Since 2001 have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?..... Yes No
- If yes _____
- Are you on a special diet? Please Explain..... Yes No
- If yes _____
- Do you currently use tobacco products?..... Yes No
- If yes _____
- Are you allergic to any of the following?
- Aspirin Penicillin Codeine Acrylic Metal
- Latex Sulfa Drugs Local Anesthetics Season Food
- Other? _____
-

WOMEN: Are you...

- Pregnant/Trying to get pregnant?..... Yes No
- Nursing?..... Yes No
- Taking oral contraceptives?..... Yes No
- Hormone replacement therapy?..... Yes No
- If pregnant, how many weeks? _____

HEART CONDITIONS: Have you had any of the following heart conditions?

- Artificial (prosthetic) heart valve..... Yes No
- Damaged valves in transplant heart..... Yes No
- Heart Attack/Failure..... Yes No

Heart Murmur..... o Yes o No
 Heart Trouble/Disease..... o Yes o No
 Irregular Heartbeat..... o Yes o No
 Previous infective endocarditis..... o Yes o No
 Angina..... o Yes o No
 Pacemaker..... o Yes o No
 If yes, when? _____

CONGENITAL HEART DISEASE:

Unrepaired, cyanotic (CHD)..... o Yes o No
 Repaired (completely) in last 6 months?..... o Yes o No
 Repaired CHD with residual defects..... o Yes o No

Do you have, or have you had, any of the following?

- AIDS/HIV Positive
- Hemophilia
- Radiation Treatments
- Diabetes I
- Hepatitis A
- Anaphylaxis
- Diabetes II
- Hepatitis B or C
- Anemia
- Herpes
- Rheumatic Fever
- Emphysema
- High Blood Pressure
- Arthritis/Gout
- Epilepsy or Seizures
- Scarlet Fever
- Excessive Bleeding
- Excessive Thirst
- Asthma
- Fainting Spells/Dizziness
- Sinus Trouble
- Blood Disease
- Kidney Problems
- Breathing Problems
- Frequent Headaches
- Liver Disease
- Stroke
- Low Blood Pressure
- Swelling of Limbs
- Cancer
- Glaucoma
- Lung Disease
- Thyroid Disease
- Chemotherapy
- Osteoporosis
- Tuberculosis
- Cold Sores/Fever Blisters
- Pain in Jaw Joints
- Tumors or Growths
- Ulcers
- Psychiatric Care
- Venereal Disease
- Yellow Jaundice
- Drug Addiction
- Tobacco Use

Artificial Joint (hip, knee, elbow, finger, ankle) o Yes o No
 If yes _____

Do you have an autoimmune disease?..... o Yes o No
 If yes _____

Has a physician recommended that you take antibiotics prior to dental treatment?
 o Yes o No If yes _____

Have you ever had any serious illness not listed above? o Yes o No
 If yes _____



HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Name of Parent or Guardian (if different than patient): _____

1. I hereby authorize all health care providers to use and/or disclose the protected health information ("PHI") described below to me or as directed below. The purpose of this request is for personal reasons.
2. I hereby authorize the release of PHI, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information. I understand that my personal billing, financial, and insurance information may be disclosed to those in paragraph 3 in order to be able to process claims with the insurance company and/or for personal reasons.
3. In addition to the authorization for release of my PHI described in paragraph 3 of this Authorization, I authorize disclosure of information regarding my/my child's billing, condition, treatment and prognosis to the following individual(s) (please include caregivers that my accompany children to appointments):
 Name: _____ Relationship: _____
 Name: _____ Relationship: _____
 Name: _____ Relationship: _____
4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until I am no longer a patient at the practice, or until such time as I render payment for my own treatment, or _____, (date or event) at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.
7. I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that payment will be collected at the time services are provided and I will be responsible for filing any claims with my dental insurance company.

Signature of Patient: _____ Date: _____

Consent for Dental Treatment

COVID-19 Waiver

I understand that there is presently a public health emergency as declared by the President of the United States and the Governor of this State. I understand that being in public and/or receiving dental treatment at this time may present an increased risk of the transmission and/or the contraction of COVID-19. While the Provider will take the necessary precautions in order to reduce the risk of such transmission during any dental treatment and/or procedure, at this time there is no way to guarantee such procedure and/or treatment will be completely risk free.

I hereby knowingly and freely acknowledge, and assume any and all risks, known and unknown, related to the potential contraction of COVID-19 during the dental procedure and/or treatment, and assume full responsibility for such risk. I hereby agree to indemnify and hold harmless the Provider, its employees, officers, owners, doctors, directors, members, managers, members, contractors, agents and/or representative from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, which may be brought as a result of the dental procedures and/or treatment provided on the date identified below or hereafter as such treatment and/or procedure may be related to the contraction of COVID-19.

The undersigned, on behalf of myself as well as any of my heirs, personal representative or assign, hereby release, waive, discharge, and covenant not to sue the Provider, or any of the provider's employees, officers, owners, doctors, directors, members, managers, contractors, agents and/or representatives for any and all claims, known or unknown, which may be related to the transmission and/or contraction of COVID-19, including but not limited to claims which may result in personal injury, illnesses (including death), loss of income or other property loss.

I have read this document and discussed all of the above with the Provider, and all my questions have been answered to my satisfaction.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

Following the explanation, the discussion, and the answers to my questions, I authorize the Provider to complete the treatment as described.

Patient Signature: _____

Print Patient Name: _____

Financial Policy

Welcome to our practice! We are pleased you have chosen us and we are committed to your successful dental health treatment. In order to achieve this, your assistance and compliance with our payment and insurance coverage policies are necessary.

- Full payment is expected at the time services are rendered.
- You are responsible for determining your insurance coverage.
- Coverage issues can only be addressed by your employer or group plan administrator.
- **Please provide all insurance information.**

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder Member Number or SSN: _____

Policy Holder's Employer: _____

Insurance Carrier's Name and Address: _____

- All deductibles and patient percentages are due before insurance claims are filed.
- It is the patient's responsibility to follow up on denied claims.
- Regardless of insurance coverage, you are responsible for payment on all charges.
- We accept cash, checks, Visa, Mastercard, and Discover.
- Finance charges may be applied to all balances over 90 days at 1.5%.
- All balances over 120 days are automatically turned over to a collection's agency.
- No minors will be treated without a parent or legal guardian present.

As a courtesy to our patients, we file to the primary insurance company. Please be aware, some insurance plans may not consider the fees charged by this provider to be reasonable and necessary. You are responsible for all charges regardless of insurance company's arbitrary determination of usual and customary. Please be aware, if you do not provide all the necessary insurance information, we will be unable to file your insurance.

I understand I am responsible for paying attorney's fees and all collection expenses incurred and expanded in the vent my account is referred to Magistrate Court, an attorney, or a collection agency.

I have read, understand and agree to this financial policy.

Signature: _____ Date: _____

Missed/Cancelled Appointments

We are a busy practice and often have a waiting list. Our office requires 48 hours' notice for any cancellations. If you have a Monday appointment you must cancel by Thursday at noon.

Missed appointments have a 3-strike policy; 1st missed appointment is excused. For the 2nd missed appointment you will be charged a \$75 fee. After the 3rd missed appointment, we will no longer schedule you and you will be dismissed from our practice.

I have read this information and agree to adhere to the policies.

Signature: _____ Date: _____