PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Wireless Carrier_____

Email_____ Text OK?_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email Text

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email Text

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email Text

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:

Dentistry for Adults: Medical History for New Patient

Last Name: _____ First Name: _____ Birthdate: _____
Name of Medical Doctor: _____ City/State: _____
Emergency Contact _____ Phone _____ Relationship _____

List all medications that you are now taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever

Additional Medications, Allergies, Problems, or Surgeries not listed above:

Tobacco use? If so, what kind and how much? _____
Unusual reaction to dental treatment? _____
Reason for today's visit _____ Are you in pain? _____
New patients:
Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____
Do you have BiteWing x-rays that are less than 1 year old? _____
Name of former dentist _____ City/State _____
Date of last cleaning and exam _____
Have you been told you need PRE-MEDICATION for Dental Treatment? _____

To the best of my knowledge, all of my answers and information provided are true and correct. If i ever have any change in my health, I will inform the office at the next appointment without fail.

Date: _____ Signature of patient or guardian: _____

Notice of Privacy Policies

Last Name: _____ First Name: _____ Birthdate: _____

Date: _____

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

_____

Signature of patient, parent or guardian

HIPAA release form

Last Name: _____ First Name: _____ Birthdate: _____

Date: _____

Electronic communication

Unencrypted email and texting is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information contained in such email or text may be misdirected, disclosed to, or intercepted by unauthorized third parties.

However, you may consent to receive email or texts from us regarding your treatment.

We will use the minimum necessary amount of protected health information in any communication.

	YES	NO
I consent to and accept the risk in receiving information via email and texts. I understand I can withdraw my consent at any time.	☐	☐

My email address is: _____

My phone number to text is: _____

Medical Information Release

	YES	NO
I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information.	☐	☐

If YES, the information may be released to the following individuals:

Spouse _____

Children _____

Other _____

_____

Signature of patient, parent or guardian

Consent for Services

Last Name: _____ First Name: _____ Birthdate: _____

Date: _____

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that a fee estimate listed for the dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I grant my permission to you or your assignee to use my name, comments (in complete or edited form), photograph(s) or any other image as may be necessary of me, with or without my given name and city for advertising, education or any other lawful purpose and I release and forever discharge said Doctor from any claim, demands or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

I have read the above conditions of treatment and payment and agree to their content.

_____

Signature of patient, parent or guardian

Cancellation/Missed Appointment Policy

Last Name: _____ First Name: _____ Birthdate: _____

Our goal is to provide quality dental care in a timely manner. In order to do so, we have had to implement an appointment cancellation policy. This policy enables us to better utilize available appointments for our patients needing immediate care.

Cancellation of an Appointment:

In order to be respectful of the dental needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we ask that you call at least 24 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care.

No-Show Policy:

A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. "No-shows" inconvenience those individuals who need access to dental care in a timely manner, as well as our clinical staff. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a “missed appointment”. The first time there is a "no-show" there will be no charge to the patient. Any additional "no shows" will result in a fee of $40.00.

Late Cancellations:

Late cancellations will be considered as a "no-show". Cancellations made less than 24 hours in advance of your scheduled appointment time will be assessed a cancellation fee.

I understand this policy and authorize Dentistry For Adults to assess cancellation and no show fees according to the above outlined policy.

Date: _____

_____

Signature of patient, parent or guardian