

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 _____	
Birthdate _____	MI (Preferred) _____
SS# _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F Married: <input type="checkbox"/> Y <input type="checkbox"/> N
Work Phone _____	Wireless Phone _____ Wireless Carrier _____
Email _____	Text OK? _____
Preferred contact method _____	<input type="checkbox"/> HmPhone <input type="checkbox"/> WkPhone <input type="checkbox"/> WirelessPh <input type="checkbox"/> Email Text
Preferred contact method for confirmations _____	<input type="checkbox"/> HmPhone <input type="checkbox"/> WkPhone <input type="checkbox"/> WirelessPh <input type="checkbox"/> Email Text
Preferred contact method for recall _____	<input type="checkbox"/> HmPhone <input type="checkbox"/> WkPhone <input type="checkbox"/> WirelessPh <input type="checkbox"/> Email Text
Student status if dependent over 19 (for ins) _____	<input type="checkbox"/> Nonstudent <input type="checkbox"/> Fulltime <input type="checkbox"/> 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 <input type="checkbox"/>	
Address _____	
Address 2 _____	
City _____	State _____ Zip _____
Home Phone _____	
INSURANCE POLICY 1	
Your relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Subscriber Date of Birth _____
Subscriber Name _____	Subscriber ID # _____
Insurance Company _____	Phone _____
Employer _____	Group Name _____ Group # _____
Please present insurance card to receptionist.	
INSURANCE POLICY 2	
Your relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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

Anesthetic

Aspirin

Codeine

Ibuprofen

Y N

Iodine

Latex

Penicillin

Sulfa

Do you have any of the following medical conditions?

Y N

Asthma

Bleeding Problems

Cancer

Diabetes

Heart Murmur

Heart Disease

High Blood Pressure

Joint Replacement

Y N

Kidney Disease

Liver Disease

Pregnancy

Psychiatric Treatment

Sinus Trouble

Stroke

Ulcers

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.	<input type="checkbox"/>	<input type="checkbox"/>

My email address is: _____

My phone number to text is: _____

	YES	NO
Medical Information Release I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information.	<input type="checkbox"/>	<input type="checkbox"/>

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