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Welcome Forms

Patient Information *(Confidential)*

_____ _____/_____/_____
First Name Middle Initial Last Name Date

_____
Address City State Zip Code

(_____)_____-_____ (_____)_____-_____ _____-_____-_____ _____/_____/_____
Home Phone Number Cell Phone Number Social Security Number Date of Birth

Email: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

_____ (_____)_____-_____
Patient's Employer Work Phone Number

_____
Business Address City State Zip Code

_____ (_____)_____-_____
Spouse's Name Phone Number

Whom may we thank for referring you? _____

_____ (_____)_____-_____
Emergency Contact Relationship to Patient Phone Number

College Students:

☐ Full Time ☐ Part Time _____
School Name City State

Responsible Party *(If someone other than yourself handles your accounting)*

_____ (_____)_____-_____
Name Relationship to Patient Phone Number

_____
Address City State Zip Code

_____ _____-_____-_____ _____/_____/_____
Drivers License Number Social Security Number Date of Birth

_____ (_____)_____-_____
Employer Work Phone Number

_____
Business Address City State Zip Code

_____ _____/_____/_____
Signature of Patient, or Parent if minor Today's Date

Insurance Information:

Primary Dental Insurance Information:

_____ _____ _____/_____/_____
Name of Insured | Relationship to Patient | Date of Birth

_____-_____-_____ _____ _____ (_____)_____-_____
Social Security Number | Policy ID Number | Group Number | Insurance Phone Number

_____ (_____)_____-_____
Employer | Work Phone Number

_____
Claims Address | City | State | Zip Code

Secondary Dental Insurance Information:

_____ _____ _____/_____/_____
Name of Insured | Relationship to Patient | Date of Birth

_____-_____-_____ _____ _____ (_____)_____-_____
Social Security Number | Policy ID Number | Group Number | Insurance Phone Number

_____ (_____)_____-_____
Employer | Work Phone Number

_____
Claims Address | City | State | Zip Code

Major Medical Insurance – Primary:

_____ _____ _____/_____/_____
Name of Insured | Relationship to Patient | Date of Birth

_____-_____-_____ _____ _____ (_____)_____-_____
Social Security Number | Policy ID Number | Group Number | Insurance Phone Number

_____ (_____)_____-_____
Employer | Work Phone Number

_____
Claims Address | City | State | Zip Code

Major Medical Insurance – Secondary:

_____ _____ _____/_____/_____
Name of Insured | Relationship to Patient | Date of Birth

_____-_____-_____ _____ _____ (_____)_____-_____
Social Security Number | Policy ID Number | Group Number | Insurance Phone Number

_____ (_____)_____-_____
Employer | Work Phone Number

_____
Claims Address | City | State | Zip Code

_____ _____/_____/_____
Signature of Patient, or Parent if minor | Today's Date

Medical History:

_____ _____/_____/_____
Patient Name Date of Birth

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 that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health	☐	☐
2. Have there been any changes in your general health this past year	☐	☐
3. Date of your last physical exam: _____		
4. Physician's Name: _____		
Address: _____		
City/State/Zip Code: _____		
Phone Number: ( )_____-_____		
5. Are now under the care of a Physician	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness	☐	☐
Please explain: _____		
7. Are you taking any medications, including non-prescription	☐	☐
If yes, what medicine(s) are you taking: _____		
_____		
_____		
8. Have you had any abnormal bleeding	☐	☐
9. Do you bruise easily	☐	☐
10. Have you ever required a blood transfusion	☐	☐
11. Have you had a recent weight loss	☐	☐
12. Have you ever taken Fen-Phen or Redux	☐	☐

	YES	NO
13. Do you use tobacco products	☐	☐
14. Do you or have you used controlled substances	☐	☐
15. Are you wearing contact lenses	☐	☐
16. Do you have any disease, condition, or problem not listed above that you think we should know about:_____		
_____		
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:		
Local anesthetics like novocaine	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin	☐	☐
Iodine	☐	☐
Any metals (e.g., nickel, mercury, etc.)	☐	☐
Latex /Rubber	☐	☐
Other (please list) _____	☐	☐
_____		
WOMEN ONLY:		
Are you pregnant or think you may be pregnant	☐	☐
Are you nursing	☐	☐
Are you taking birth control	☐	☐

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	YES	NO
Rheumatic heat disease or rheumatic fever	☐	☐
Scarlet Fever	☐	☐
Heart defect or heart murmur	☐	☐
Heart Trouble, heart attack, or angina	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Pacemaker	☐	☐
Heart Surgery	☐	☐
High/Low blood pressure (circle one or the other)	☐	☐
Eating Disorders	☐	☐
Congenital heart problem	☐	☐
Swelling of the feet, ankles or hands	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Stroke	☐	☐
Sinus trouble	☐	☐
Lung of breathing problems	☐	☐
Asthma or hay fever	☐	☐
Hives or skin rash	☐	☐
Fainting or dizzy spells	☐	☐
Mental Health care	☐	☐
Back problems	☐	☐
Chemical Dependency	☐	☐

	YES	NO
Diabetes	☐	☐
AIDS or HIV infection	☐	☐
Thyroid problems	☐	☐
Allergies	☐	☐
Arthritis or Rheumatism	☐	☐
Joint replacement or implant	☐	☐
Stomach Ulcer	☐	☐
Kidney trouble	☐	☐
Tuberculosis	☐	☐
Persistent cough	☐	☐
Cough that produces blood	☐	☐
Chemotherapy	☐	☐
Sexually Transmitted Disease(s)	☐	☐
Epilepsy or seizures	☐	☐
Anemia	☐	☐
Glaucoma	☐	☐
Nervousness	☐	☐
Tonsillitis	☐	☐
Tumors	☐	☐
Mitral valve prolapse	☐	☐
Cortisone Treatment	☐	☐
Hypoglycemia	☐	☐

Dental History:

_____ _____/_____/_____
Patient Name Date of Birth

Reason for today's Visit:

☐	Accident	☐	"Buck" or Protruding Teeth	☐	Clicking of Jaw Joint
☐	Crowded Teeth	☐	Facial Pain	☐	Gum Disease or Recession
☐	Head Pain	☐	Irregular Facial Proportions	☐	Jaw Dysfunction
☐	Jaw Pain	☐	Mismatched Bite	☐	Missing Teeth
☐	Neck Pain – Frequent	☐	Prominent Jaw	☐	Overbite
☐	Overly Small Mouth	☐	Tooth Spacing – Excessive	☐	Receded Jaw
☐	Second Opinion	☐	Due for a cleaning	☐	Periodontal Problems

☐ Referred by another doctor for: _____

☐ Other, please explain:_____

_____

When was your last dental visit _____. What was done at that visit: _____

How often did you visit the dentist before that time?_____

_____ ( )_____-_____ _____
Previous Dentist Name Phone City/State

When was your last complete series of dental x-rays taken? _____ At the above dentist? ☐YES ☐NO

How often do you brush your teeth? _____. How often do you floss your teeth? _____

Is your drinking water fluoridated? ☐YES ☐NO

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing	☐	☐	Have you noticed any loosening of your teeth	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐	Does food tend to become caught between your teeth	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐	Have you ever had periodontal treatment (gums)	☐	☐
Do you feel pain in/to any of your teeth	☐	☐	Ever worn a bite plate or other appliance	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐	Have you ever had any difficult extractions in the past	☐	☐
Have you had any head, neck or jaw injuries	☐	☐	Have you ever had any prolonged bleeding following extractions	☐	☐
Have you ever experienced any of the following problems in your jaw?			Do you wear dentures or partials	☐	☐
Clicking	☐	☐	If yes, date of placement: _____		
Pain (joint, ear, side of face)	☐	☐	Have you ever received oral hygiene instructions regarding the care		
Difficulty in opening or closing	☐	☐	of your teeth and gums	☐	☐
Difficulty in chewing	☐	☐	Have you had orthodontic work/braces in the past	☐	☐
Do you have frequent headaches	☐	☐	Would you be interested in teeth whitening	☐	☐
Do you clench or grind your teeth	☐	☐	Have you had an unfavorable dental experience	☐	☐
Do you bite your lips or cheeks frequently	☐	☐	Explain: _____		

If you could change anything about your smile, what would you change? _____

_____

_____

Appointment Note: Once an appointment is made, please remember this time has been reserved for you. When you show up late or cancel at the last minute it drastically affects our schedule. Also note that our schedule books up almost a month in advance, and your chances of being seen sooner depend on everyone making appointments they know they can keep. Although we do understand that things come up that are beyond your control. All we ask is that you let us know as soon as is possible. If you continuously cancel your appointments we may charge you a minimum fee, or schedule you for less time and do each procedure separately.

Also note that because of things that are beyond our control, our schedule may be running late from time to time. As with any Doctor's office, it is difficult to give an exact amount of time a procedure is going to take, as it changes with each patient's circumstance. Please remember this when scheduling your appointment.

Office Financial Policy:

_____ ____/____/_____
Patient Name Date of Birth

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 understanding of our payment policy.

Self-pay patients: Payments for services rendered is due at each visit. We accept cash, checks and all major credit cards. We will provide you with an itemized statement so that you may file reimbursement with your Medical Savings Account or Insurance carrier.

HMO/ Discount Insurance plan patients: We do not accept HMO insurance. Nor do we accept any kind of Discount Insurance plans. You will be expected to pay in full at the time of visit.

PPO Insurance patients: Payment for any deductibles or estimated co-pays specified by your insurance is due at each visit in full. If your insurance company pays more than their estimated sum, you have the choice of requesting the additional sum refunded to you by check or keeping it as a credit on your account. If your insurance does not pay as much as we estimated, we will send a bill requesting payment for the remaining sum. For any account that is past due more than 90 days a finance charge of 1.75% will be added to your account balance. Regardless of how things have been done in the past, this is the only policy we are accepting at this time, unless a private financial agreement has been arranged.

We must stress the following:

1. Your insurance is a contract **between you, your employer and the insurance company**.
2. Not all services rendered are covered expenses. Some insurance companies arbitrarily disallow payment for certain services. These non-covered charges become your responsibility. **Being familiar with your own policy is the only way of knowing what your insurance will and will not cover**. This should help avoid any unpleasant surprises that may arise.

For those services which are lengthier or more costly in performing we have different payment options available to you. We require that a payment arrangement is made prior to your first treatment appointment. Therefore, if you would like to know the cost of service, you are responsible for asking prior to treatment. Please note, most of our services, even lengthier services, are a flat fee rate and are then applied on the date prepared, not necessarily the date the item is placed.

While a procedure is being done, if something unforeseen occurs resulting in the need for additional treatment during this same visit, we will do our best to make sure you understand exactly what has happened and why. If you cannot then afford the new charges for that day, payment options can be arranged.

We offer the following choices of payment arrangements:

1. You may choose to pay in full for a group of treatment ($2000 or more) and receive a 5% discount. If you choose this plan, the full amount must be received at least one week prior to your appointment in order to receive the discount.
2. You may sign up with a third party financing group, such as CareCredit and, if accepted, use this resource to pay for the full or a group of the treatment planned. We offer to pay off your interest rate for up to 12 months.
3. You may break up payments for a group of treatment for up to 3 monthly payments. One-Third will be due one week prior to your first appointment date. The next third will be due a month later. The last payment is due two months after your first payment. Please note that even though treatment may be longer than 3 months, payment must be made within 3 months.

I have read and understand this policy in its entirety and agree to its terms completely.

_____ ____/____/_____
Signature of patient Today's Date

_____ ____/____/_____
Signature of parent (if a minor), or responsible party Today's Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, and cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written requirest to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

I certify that I have read and understand the information in these welcome forms to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered 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.

_____ _____/_____/_____

Signature of patient Today's Date

_____ _____/_____/_____

Signature of parent (if a minor), or responsible party Today's Date