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Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: ____-____-____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

Whom may we thank for referring you to our practice?

Referral Name: _____

Emergency Contact Name and Phone number:

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment ☐ both ☐ not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2
City State Zip Code

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or you are the parent/guardian of the patient.

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ both ☐ neither-not applicable

Name: _____
Last First MI Preferred Name

Title: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: ____-____-____ DL#: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City State Zip Code

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Company Phone Number: _____

Secondary Dental Insurnace

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Company Phone Number: _____

Medical Insurance

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Authorization:

- ☐ * By checking this box,
I authorize my insurance company (Medical and Dental) to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services 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. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

You, as the holder of the insurance policy, are ultimately responsible for knowing what your plan does and does not cover and the administrative rules (such as referrals, authorizations, etc.).

Any amounts not covered by your plan, are your responsibility. Please take some time to read over our Office Policies below so that we can establish a mutual understanding of any situations that could arise. Please read and initial each item below.

If I was given a special price for a single or multiple procedures for a near or a far future treatment, I agree that the payment done is nonrefundable unless provided otherwise,

Please be on time for your reserved appointments. We have exclusively reserved the doctor, staff, and facility for your personal dental care. If you need to cancel or reschedule an appointment, please let us know 48 hours in advance. If an appointment is cancelled or rescheduled within the 24 hours before the appointed time, a charge based on the appointment time and length will be requested.

· If you are thirty or more minutes late for our appointment it will be considered a "no show" and rescheduled to another day. You will be assessed a charge based on the appointment type and length to your account.

· For any appointment's scheduled for two hours or longer, in addition to any type of surgery, we require 20% NON REFUNDABLE DEPOSIT of the total treatment scheduled for that day. We will retain the deposit if the appointment is cancelled or rescheduled within 48 hrs before the appointment.

☐ * **By Checking this box, I acknowledge that I have read this statement and agree to the contents.**

NO SHOWS AND CANCELLATIONS: Our office will charge you for appointments that you do not keep and for appointments that you do not cancel with 24 hour notice from the appointment time. The fee could vary depending on the appointment details.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Our office respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur.

Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number

you provide to us on your account. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be

intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text.

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account

Information.)

Name and Relationship to Patient:

☐ * By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Response Date: _____