

NEW PATIENTS FORM

**WELCOME
TO OUR
PRACTICE**

Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Date: ____ - ____ - ____

Who may we thank for referring you to us

Patient Information (Confidential): (PLEASE TYPE OR PRINT)

Name: _____

Birth Date: ____ - ____ - ____ Social Security Number: ____ - ____ - ____ Sex: M / F

Address: _____

City: _____ State: _____ Zip Code: _____ Height: _____ Weight: _____

Marital Status: Minor Single Married Divorced Widowed

Email: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Person to contact in case of an emergency: _____ Ph: _____

Patient's or parent's employer: _____

Business Address: _____ City: _____ St: _____ Zip: _____

Spouse or parent's name: _____ Employer: _____

Phone: _____ Relationship to patient: _____

Person Responsible for this account: (If different than patient): _____

Phone Number: _____ Is this person currently patient is this office? Yes No

Insurance Information: (PLEASE PRINT)

Primary Insurance:

Name of insured: _____ Relationship to patient: _____

Date of birth: ____ - ____ - ____ Effective Date: ____ - ____ - ____ Social Security #: ____ - ____ - ____

Insurance Co: _____ Address: _____

City: _____ State: _____ Zip: _____ Group#: _____

Employer name: _____ Address of employer: _____

City: _____ State: _____ Zip: _____ Insurance Phone Number: _____

Secondary Insurance:

Name of insured: _____ Relationship to patient: _____

Date of birth: ____ - ____ - ____ Effective Date: ____ - ____ - ____ Social Security #: ____ - ____ - ____

Insurance Co: _____ Address: _____

City: _____ State: _____ Zip: _____ Group#: _____

Employer name: _____ Address of employer: _____

City: _____ State: _____ Zip: _____ Insurance Phone Number: _____

Dental History: (answer to the best of your knowledge)

Check Yes or No if you have or had any of the following:

Yes No

- Bad breath
- Chew of one side of mouth
- Fingernail biting
- Gum swollen or tender
- Mouth breathing
- Periodontal treatment
- Sensitivity when biting
- Clicking or popping of jaw
- Dry mouth

Yes No

- Bleeding gum
- Cigarette, pipe or cigar smoking
- Food collection between teeth
- Jaw pain or tiredness
- Mouth pain while brushing
- Sensitivity to sweet
- Sores or growths in your mouth
- Frequent blisters
- Do you floss at least once a day?

Yes No

- Foreign objects
- Lip or cheek biting
- Orthodontic treatment
- Sensitivity to heat or cold
- Burning sensation of tongue
- Grinding teeth
- Loose teeth or broken fillings
- Pain around ear
- Do you brush at least once a day?

Health History: (answer to the best of your knowledge)

Check Yes or No if you have or had any of the following:

Yes No

- AIDS/HIV.
- Hepatitis A.
- Hepatitis B, C, _____
- Artificial joints/pins.
- Blood Disease.
- Circulatory Problems.
- Diabetes.
- Jaw pain
- Congenital Heart Lesions.
- Skin Rash
- Thyroid problems
- Ulcers
- Artificial heart valve.
- Heart defects

Yes No

- Mitral valve prolapse
- Radiation treatment
- Shortness of breath
- Swelling of feet and ankles
- Tuberculosis
- Unexplained weight loss
- Anemia
- Asthma
- Cancer
- Bleeding abnormality
- Chemotherapy
- Fainting or dizziness
- Heart problems.
- Autoimmune disease

Yes No

- Emphysema.
- Headaches.
- Herpes.
- Kidney Disease.
- Sinus Problems.
- Respiratory Disease.
- Nervous problems.
- Swollen neck glands.
- Tumors or growths.
- Arthritis, Rheumatism.
- Jaundice.
- Low blood pressure
- Psychiatric care
- Scarlet fever
- Ever taken Phen Phen

Yes No

- Back problems.
- Chemical dependency.
- Steroid treatment.
- Epilepsy / Seizures.
- Heart murmur.
- High blood pressure.
- Liver disease.
- Pacemaker.
- Rheumatic Fever.
- Cough, persistent or bloody.
- Stroke
- Tonsillitis
- Venereal Disease.
- Osteoporosis

For Females Only:

- Are you taking birth control medication or are on any other birth control system? Yes No
- Are you breast-feeding? Yes No

If you are pregnant or if there is a chance you could be pregnant, please notify the office staff immediately (**this applies to this appointment or any other future appointment**)

Reason for today's visit: _____

Former Dentist: _____ City/State: _____

Date of last visit: _____ Date of last x-ray: _____

Are you nervous about your dental treatment? Yes No Is there anything about your smile you don't like? Yes No

Have you been instructed how to prevent tooth decay? Yes No Do you like the appearance of your teeth? Yes No

Do you feel you have unpleasant breath at times? Yes No Are your teeth all aligned? (straight) Yes No

Please describe any other health condition that you might have and not included in the list above:

Are you currently taking any medication? Yes No (if yes then please list all medication you are taking):

Do you have any drug allergies? Yes No (if yes, please provide a list of medication you are allergic to):

Video Surveillance: This facility is equipped with a video surveillance system. This is done for your protection and for the protection of this facility and its operators.

Photography: We take photos of all patients, and are used on a regular basis for diagnostic, teaching and some cases for marketing reasons. All privacy etiquettes are followed. If you have any questions or concerns, please talk to one of our team members.

Telephone Calls: All telephone calls made to and out of this office may be recorded without prior notification.

FINANCIAL, TREATMENT POLICY AND CONSENT

Please read and ask questions if you do not understand, then sign this policy:

THANK YOU for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our **FINANCIAL POLICY**. If you have any questions, please ask to speak with the Office Manager.

As a courtesy to you, we will verify your insurance for eligibility and benefits prior to your initial visit as well as any time you notify us of a change in your coverage. We cannot guarantee that the information we receive is a guarantee of payment. Insurance companies state that coverage is only an **estimation** of benefits. You are ultimately responsible for knowing what your plan covers or do not cover and if there are waiting periods for work to be performed. Any amounts not covered by your plan, except for contractual fee discounts, are your financial responsibility.

Balances Due Per the Explanation of Benefits (EOB): After my insurance has processed the insurance claim, balances are due immediately upon receipt of a bill from this office. If I disagree with the amounts due per my EOB, it is not only my responsibility to contact the insurance company immediately for resolution of the problem, but also to pay any balances due to this office at that time pending the resolution of the problem with the insurance company.

New Insurance Information as well as **Changes in Insurance** must be provided to this office prior to any appointment. Failure to provide correct and current insurance information may result in the entire bill being my own responsibility.

Insurance Requests for Additional Information must be responded to immediately. This includes documentation of college student's full time status, proof of continued enrollment in insurance plan (usually following open enrollment), and dual insurance verification. Failure to provide this information to the insurance company in a timely manner may result in the entire bill being my own responsibility.

Statements are sent on monthly basis and as needed. I will remit payment by mail immediately upon receipt of a bill. I agree to contact the office immediately if I have any questions regarding a bill I may receive. Bills are not sent out only for informational purposes, but to notify me of payment expected from this office.

Balances That Exceed 90 Days: I understand that if I allow my account balance to exceed 90 days, I may receive a **Final Notice** letter. Failure to pay my account or arrange a payment plan within 10 days may result in my account being turned over to a collections agency. If this happens, a **Collection Fee** of 29% of the balance sent to the collection agency will be added to my account balance, and I will have to find another dentist within 30 days. I understand that the collection agency will report unpaid balances to the major credit bureaus, and this will remain on my credit report for 7 years. Before I can be seen in this office again, I understand that all fees must be paid. All billing of accounts 60 days overdue will carry an interest of 18% and a billing charge of \$15 on every billing cycle.

Changes in Address or Telephone Numbers should be provided immediately as soon as a change occurs. I understand that if the office cannot contact me via telephone or mail about my outstanding balance, my account will be turned over to a collections agency for further collection activity.

Returned Checks will incur a \$30 fee (or whatever the law allows). The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card. I understand that the office will no longer accept personal checks for payment once a check is returned. And no further treatment will be rendered until all owed amount is paid.

We do not treat our patients according to insurance companies' policies: If your insurance company decides not to cover a procedure, it will be your responsibility to pay the claim. We only treat you according to your dental needs, not according to insurance policies.

Changes made by insurance company on your benefits: This office is not responsible for changes made by your insurance company on the procedure code done and billed by our office. (Example would be: a certain procedure is done in this office, and changed by your insurance company to a different procedure benefit or several procedures bundled into one benefit)

We do not use silver (amalgam) filling in this office: if your insurance company changes any procedure done in this office to a silver filling code, you are responsible for the difference in price.

We take necessary radiographs: for diagnosis reasons and to comply with the standard of care and the needs of the doctors for diagnosis. This office is not responsible if insurance denies a radiograph claim for any reason.

Cosmetic procedures are done in this office on a regular basis at the consent of patients. You are ultimately responsible for the balance if your insurance company determine the procedure unnecessary for cosmetic reason.

Assignment of benefits: We will file your insurance as a courtesy to you on the understanding benefits are a contract between you and your insurance, and in the event your insurance denies coverage or payment, you are ultimately responsible for the remaining balance. By signing this agreement you (or any of your dependents) assign directly to this dental office and dentists all insurance benefits, otherwise payable to you as service rendered. You are also giving us authorization to release all information necessary to secure the payment of benefits. Your signature will be also used for all insurance submission.

Consent for treatment: This signature also serves as consent for basic treatment (cleaning, exam, radiographs, and application of fluoride, taking vital signs...). If you have any objection to any basic treatment, please notify us.

Please ask one or our team members if you have any other questions about our treatment and financial policies. The office financial policy is subject to change, and fair changes will apply to all existing and new patients without notice or prejudice.

Video Surveillance: This facility is equipped with a video surveillance system. This is done for your protection and for the protection of this facility and its operators.

Photography: We take photos of all patients, and are used on a regular basis for diagnostic, teaching and some cases for marketing reasons. All privacy etiquettes are followed. If you have any questions or concerns, please talk to one of our team members. If you do not agree with this clause, Please notify us.

Telephone calls: All telephone calls made to and out of this office may be recorded without prior notification.

Please sign below to acknowledge understanding of the entire financial policy:

(Please print Patient's Name)

(Date)

(Patient's Signature/Parent or Guardian's Signature if a Minor)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or is disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: