SENSIBLE DENTISTRY

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PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____Cell: _____ E-mail: _____

Pref. Method of Contact: ❑ Home ❑ Cell ❑ Work ❑ E-mail ❑ Text

❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Name of Spouse: _____ Phone: _____

Patient's Employer: _____ Wk. Ph: _____

Alternate Emergency Contact: _____ Phone: _____

How did you hear about our practice? _____

Name of person ultimately responsible for account (if different from above): _____

Relationship to patient: ❑ Spouse ❑ Parent/Guardian ❑ Other Phone: _____

SS#: _____ Date of Birth: _____ Driver's License #: _____

Name of Insured: _____ Date of Birth: _____

Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child SS#: _____

Employer: _____ Phone: _____

Insurance Co.: _____ Phone: _____

Member ID#: _____ Group #: _____

____ (INITIALS) I HEREBY AUTHORIZE ASSIGNMENT OF MY INSURANCE RIGHTS AND BENEFITS DIRECTLY TO THE PROVIDER FOR SERVICES RENDERED. I FULLY UNDERSTAND I AM SOLELY RESPONSIBLE FOR ANY BALANCE NOT PAID BY MY INSURANCE COMPANY. I UNDERSTAND THAT PAYMENT IN FULL FOR ALL SERVICES RENDERED MUST BE PAID AT THE TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE BUSINESS MANAGER. IF ACCOUNT IS NOT PAID WITHIN 90 DAYS OF THE DATE OF SERVICE AND NO FINANCIAL ARRANGEMENTS HAVE BEEN MADE, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR LEGAL FEES, COLLECTION AGENCY FEES, INTEREST CHARGES AND ANY OTHER EXPENSES INCURRED IN COLLECTING MY ACCOUNT.

DENTAL HISTORY

Are you in pain? ❑ Yes ❑ No If yes, describe pain and duration: _____

Do you require pre-medication of antibiotics for dental care? ❑ Yes ❑ No ❑ Don't know

Have you ever had a serious/difficult problem associated with any previous dental work or anesthesia? ❑ Yes ❑ No

If yes, please explain: _____

Do you feel tired throughout the day? ❑ Yes ❑ No **Do you wish you slept better and had more energy? ❑ Yes ❑ No**

Have you ever been told you occasionally snore? ❑ Yes ❑ No **Have you or a loved one been prescribed a CPAP? ❑ Yes ❑ No**

Have you ever had or are you experiencing any of the following:

❑ Accidently Biting Cheeks/Lips
❑ Bad Breath
❑ Bleeding Gums
❑ Blisters/Sores Around the Mouth
❑ Broken/Chipped Tooth
❑ Clenching/Grinding Teeth
❑ Difficulty Opening or Closing Jaw
❑ Food Impaction
❑ Frequently Have Cavities
❑ Gag Easily
❑ Nervous/Anxious When Seeing a Dentist
❑ Pain in Jaw Joints
❑ Previous Periodontal Therapy
❑ Lost/Broken Fillings
❑ Sensitive Teeth/Gums
❑ Use of Flouride Gels/Rinses
❑ Wears Dentures/Partial

Previous Dentist: _____Phone: _____Last Dental Visit: _____

Are you under a physician's care now? ❑Yes ❑No
Have you ever been hospitalized? ❑Yes ❑No
Have you ever had a serious head or neck injury? ❑Yes ❑No
Do you use tobacco? ❑Yes ❑No
Are you taking medications, pills or drugs? ❑Yes ❑No
Do you have a LATEX allergy? ❑Yes ❑No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑Yes ❑No
Are you on a special diet? ❑Yes ❑No
Do you use controlled substances? ❑Yes ❑No
Family History of Heart Disease? ❑Yes ❑No
Women: ❑Pregnant ❑Nursing ❑ Taking Oral Contraceptives

Please list all medications/hospitalizations/drug allergies:_____

_____

_____

Physician: _____ Phone #: _____ Pharmacy: _____

MEDICAL HISTORY

❑ AIDS/HIV Positive
❑ Alzheimer's Disease
❑ Artificial Heart Valve
❑ Artificial Joint
❑ Breathing Problem
❑ Cancer
❑ Chemotherapy
❑ Diabetes (type) 1 / 2
❑ Drug Addictions
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Excessive Thirst
❑ Heart Trouble/Disease
❑ Hepatitis (type) A / B / C
❑ High Blood Pressure
❑ High Cholesterol
❑ Irregular Heartbeat
❑ Leukemia
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ Mitral Valve Prolapse
❑ Organ Transplant
❑ Psychiatric Care
❑ Radiation Treatments
❑ Sinus Trouble
❑ Stroke
❑ Tumors or Growths

List Any Other Serious Medical Problems:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____ DATE: _____

SENSIBLE DENTISTRY

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA?

□ First Name Only □ Proper Surname □ Other_____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes stepparents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

□ Cell Phone Confirmation
□ Text Message to my Cell Phone
□ Home Phone Confirmation
□ Email Confirmation
□ Work Phone Confirmation
□ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

□ Cell Phone Confirmation
□ Text Message to my Cell Phone
□ Home Phone Confirmation
□ Email Confirmation
□ Work Phone Confirmation
□ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
□ **Any of the Above**
□ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please *print* name of Patient Please *sign* Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

□ It was emergency treatment
□ I could not communicate with the patient
□ The patient refused to sign
□ The patient was unable to sign because:_____

Signature of Privacy Officer: _____

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Office Appointment Policy

The doctor and staff are committed to supporting your lifelong oral health needs. Our Dental Office reserves treatment time one patient at a time. By giving you our undivided attention, you are ensured of quality dental care. We never require you to schedule an appointment, but should you do so, we do expect you to keep the appointment and to be on time. We consider reserved time as confirmed time. Preparations for you visit begin when time is reserved to ensure you receive the best comprehensive care. To maintain your optimal oral health, mutually agreed regular return visits will be necessary.

We realize life situations do arise that may prevent you from keeping a scheduled appointment. However, we appreciate the courtesy of a 48-hour cancellation notice or a broken appointment fee will incur.

We believe comprehensive dentistry can be delivered only when you and the practice are committed to meeting the best standards of care to prevent and maintain optimal oral health.

I understand the office appointment policy and will be committed to any future appointment made with the office.

Name: _____ **Date**: _____

Financial Policy

Payment is due when the service is provided unless specific arrangements are made in advance of treatment. Payments may be made with cash, check, or credit card. New patient visits and emergency visits will be made with cash or credit card at time the service is provided. No exceptions.

As a courtesy for those patients who are covered by insurance: we will accept assignment of benefits as long as we receive within on full working day prior to the date of service all the necessary information to file the insurance claim. Any balance not paid by your insurance company is solely your responsibility. This does mean you must sign the portion of your insurance form that "assigns" payment to our office.

Most dental insurance plans have limitations and do not cover 100% of the cost of treatment. You are ultimately responsible for all charges. We only estimate what the insurance will pay. We have no control over what the insurance will actually pay. The balance is your responsibility. You will be asked to pay the deductible and your estimated portion of the charges (co-pay) the day the service is provided. We try to estimate as closely as possible your coverage, but until we have actually received the payment from the insurance company, the ultimate responsibility lies with you. The balance after insurance payment is received will be due in full, from you, sixty days after services are rendered.

Accounts are considered delinquent after 90 days and are subject to collection using any methods of recovery as provided by law. Alternate arrangements may be set up with you to facilitate your treatment plan. Ask our financial coordinator for details. Feel free to ask any unanswered questions before or after treatment. We wish to be of assistance if we can.

Name: _____ Date: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the medical status of the patient. I have read and understand the above policies and my responsibilities as stated above. As the undersigned I hereby authorize the doctor and/or his employees to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a through diagnosis of the patient's dental needs. I also authorize Doctor and/or his employees to perform any and all forms of treatment, medication and therapy, that may be indicate in connection with the (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance.

_____
Patient Signature

_____ _____
Parent / Legal Representative Signature Relationship to Patient