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Welcome to our Practice

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ Last _____ First _____ MI

_____ Preferred Name

Title: _____ Mr/Ms/Mrs/etc **Gender:** ○ Male ○ Female

Family Status: ○ Married ○ Single ○ Child ○ Other

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

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Please enter Employer and Occupation _____

_____

_____

Whom may we thank for referring you to our practice?

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company 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.

If you have Secondary Dental Insurance,
please present your insurance card to the front desk at the time of your appointment.

_____

_____

_____

Responsible Party Information:

Please enter information for the person financially responsible for the account

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:** Mr/Ms/Mrs/etc ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

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

Dental Insurance Information

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:

Dental History Information

What is the reason for your visit today?

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

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

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Check all that apply:

☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Have dry mouth
☐ Food gets trapped between any teeth
☐ Have popping and/or clicking of your jaw joint
☐ Clench or grind your teeth
☐ Gums bleed when brushing or flossing
☐ Have or had gum recession
☐ Have or had a burning sensation in your mouth
☐ Would like to change the appearance of my smile
☐ Had trouble getting numb
☐ Had or have braces (orthodontic treatment)
☐ Teeth are sensitive to hot, cold, biting or sweets
☐ Have whitened or bleached your teeth
☐ Have difficulty chewing
☐ Wear or have worn a bite appliance
☐ Have been treated for gum disease
☐ Had an unpleasant taste or odor in your mouth
☐ 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 in full 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 and will credit any 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 1.5% 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 any fee estimate for this 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

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

Signature _____

Date

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,

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter 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.**

Signature _____

Date _____