PATIENT REGISTRATION (Must present copy of Driver's License and Insurance Card)

PATIENT INFORMATION

FIRST NAME: LAST NAME: MIDDLE INITIAL:

PREFERRED NAME: DATE OF BIRTH:

EMAIL ADDRESS: RECEIVE: TEXT MESSAGES? Y or N EMAIL? Y or N

SEX: ○ Female ○ Male MARITAL STATUS: ○ Married ○ Single ○ Divorced ○ Separated ○Widowed

PATIENT IS : □ Responsible Party □ Policy Holder STUDENT STATUS: ○Full Time ○ Part Time

ADDRESS:

CITY: STATE: ZIP CODE:

SOCIAL SECURITY #: EMPLOYER:

HOME PHONE: WORK PHONE: CELL PHONE:

EMPLOYMENT STATUS: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

PRIMARY DENTAL INSURANCE INFORMATION

POLICY HOLDER: Relationship to Policyholder: ○Self ○Spouse ○Child ○ Other

SOCIAL SECURITY #: DATE OF BIRTH: CONTRACT NUMBER:

EMPLOYER: INSURANCE COMPANY:

SECONDARY DENTAL INSURANCE INFORMATION

POLICY HOLDER: Relationship to Policyholder: ○Self ○Spouse ○Child ○ Other

SOCIAL SECURITY #: DATE OF BIRTH: CONTRACT NUMBER:

EMPLOYER: INSURANCE COMPANY:

RESPONSIBLE PARTY INFORMATION (if someone other than the patient)

FIRST NAME: LAST NAME: MIDDLE INITIAL:

ADDRESS:

CITY, STATE, ZIP:

HOME PHONE: WORK PHONE: CELL PHONE:

DATE OF BIRTH: SOCIAL SECURITY #: DRIVER'S LICENSE #:

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

EMERGENCY CONTACT: RELATIONSHIP: PHONE:

FOR WHOM MAY WE THANK FOR REFERRING YOUR FAMILY TO OUR OFFICE?

_____FRIEND/FAMILY (NAME) _____

_____ANOTHER DOCTOR (NAME)_____

_____INSURANCE COMPANY_____

_____OFFICE EMPLOYEE _____

_____OTHER _____

_____COMMERCIAL

_____INTERNET SEARCH / GOOGLE

_____WEBSITE

_____BILLBOARD

_____PHONEBOOK

MEDICAL HISTORY

ARE YOU TAKING BLOOD THINNERS? YES or NO

DO YOU NEED TO PRE-MEDICATE? YES or NO

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health history and medications have an important interrelationship with your dental health and dental treatment. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux?	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 tobacco?	Yes	No

Women: Are you ...

Pregnant or trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Are you allergic to any of the following?

Aspirin	**Penicillin**	**Codeine**	**Acrylic**
Metal	**Latex**	**Sulfa Drugs**	**Local Anesthetics**

Do you use controlled substances? Yes No If yes, what? _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in the Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice	Yes	No									

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Additional Comments or Health Concerns: _____

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 _____

FINANCIAL POLICY

Patient Name: _____ **Birth Date:** _____

Thank you for choosing Dental Associates for your dental needs. We are committed to your dental treatment being successful and pleasant. It is our policy to make definite financial arrangements with you prior to your treatment visit. The following is an explanation of our payment procedures and office policies. If you have any questions, please do not hesitate to ask.

1. Payment is due at the time of the services. We accept cash, checks, Visa, MasterCard, Discover, American Express, Care Credit and Compassionate Finance. We also offer an In-house Discount Plan for patients without insurance and In-house financing upon credit approval.
2. Returned Check: If a check is returned for any reason there will be a $28.00 return check fee. From that point on, checks will not be accepted (we will only accept Care Credit, Cash or Credit Card).
3. The parent or guardian who brings the child will be responsible for payment regardless of what the divorce decree may say. Reimbursement must be made between the divorced parents – we will not intervene.
4. Cancellations: Please give us at least a 24 hour notice on any appointment that cannot be kept.
5. Our policy is to forward any unpaid account to an attorney, collection agency or credit bureau for processing as bad debt. If this occurs you will be required to pay the associated legal fees.
6. Any account that is *not* paid in full in 90 days will have an added monthly 1% finance charge and a $2.00 monthly billing fee. This will incur monthly until the balance is paid in full.
7. Emergency Visits: We require payment in full at the time of the appointment.

INSURANCE

Insurance is not as easy to understand as it used to be. It is nice to have, but it is ultimately your responsibility to understand how it pays for services. We encourage you to check with your insurance company and/or employer to determine your specific coverage. Our fees are not based on what your insurance company pays. Our top concern is treating you and your family not your insurance company. We consider it a service to you to file your insurance. We *do* require you to pay any *ESTIMATED* deductibles and portions at the time of service. We must have complete and current up to date insurance information in order to bill your insurance on your behalf. In an event that your insurance has not paid their portion in 60 days, the balance then becomes YOUR responsibility.

PRE-ESTIMATES

If you would like to know exactly what your insurance will pay on services, we can submit a pre-estimate. This may take 4 to 6 weeks to receive a response from your insurance company. *Most insurance companies will let you know "this is only an estimate, not a guarantee of payment or coverage".* Pre-estimates are only sent if you request it of our financial department.

NON-COVERED SERVICES

Our doctors recommend what is best for your dental health. None of our recommendations are based on what your insurance does or does not cover. *Any service not paid for by your insurance is your responsibility*.

SECONDARY INSURANCE

Most all insurance no longer coordinate benefits. What this means to you is that your secondary insurance will only pay up to the amount that they would have paid if they were the only insurance. The only way you would receive secondary benefits is if your secondary insurance pays some better than your primary or if your primary has limits or has paid its maximum. Having 2 insurance plans does not mean that you will receive up to 100% coverage. If you have any questions concerning 2 insurance plans, please see our financial department.

DELINQUENT BALANCE

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court cost, if such be necessary.

You agree, in order for us to service your account or to collect monies you may owe, Dental Associates and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read this form and I have had an opportunity to ask any questions. I agree to the terms of this agreement. No modifications apply to this document.

NAME OF PATIENT/PARENT: _____ **SIGNATURE:** _____

RELATIONSHIP TO PATIENT: _____ **DATE:** _____

Cancellation/Missed Appointment Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a **Cancellation/Missed Appointment Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office a **24 hour notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a *missed appointment.*

A fee of ***$35*** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments will be made until this fee is paid.

If a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the ***$35*** fee will be charged.

Treatment Appointment Policy

All treatment appointments requiring an extended scheduled time will need to be secured with a debit/credit card in order to schedule your appointment. If the appointment is missed, the patient is more than 15 minutes late, or the appointment is not rescheduled within the 24 hour allowed time, a fee of $35 will be charged to the Responsible Party. After the first missed appointment, future treatment appointments will require a 25% nonrefundable deposit for the amount of the scheduled treatment in order to schedule. This is a nonrefundable deposit and will serve as the missed appointment fee charge if appointment is missed.

If you have any questions regarding these policies, please let our office staff know and we will be glad to clarify any questions you have.

I, _____, have received, read and understand the Dental Associates Cancellation/Missed Appointment Policy and the Treatment Appointment Policy and I agree to be bound by their terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____

Patient's Name (Print)

_____ _____

Signature of Patient or Parent/Guardian **Date**

OSA/TMD -SIGNS & SYMPTOMS

Patient Name: _____

Birth Date: _____ **Sex:** ____ **Male** ____ **Female**

Have you been told you snore while sleeping?	□yes	□ no
Have you been told you stop breathing while sleeping?	□yes	□ no
Do you have Sleep Apnea?	□yes	□ no
Do you have difficulty staying awake at work or school?	□yes	□ no
Do you have morning headaches?	□yes	□ no
Are you now wearing or have you ever worn a C-Pap?	□yes	□ no
Do you have Diabetes, High Blood Pressure or Thyroid Problems?	□yes	□ no
Do you have difficulty sleeping?	□yes	□ no
Do you have difficulty falling asleep?	□yes	□ no
Do you have difficulty staying asleep?	□yes	□ no
Do you have mood, memory or learning problems?	□yes	□ no
Do you have frequent urination during the night?	□yes	□ no

Do you click or grind your teeth (Bruxism)?	□yes	□ no
Do you have limited opening of the jaw?	□yes	□ no
Do you have sore muscles of the face or neck?	□yes	□ no
Do you have dry mouth or throat in the mornings?	□yes	□ no
Do you have migraine headaches?	□yes	□ no
Do you have loss of hearing?	□yes	□ no
Do you have "spots" or "floaters"?	□yes	□ no

Signature of Patient/Parent: _____

Phone Number: _____

Name of Medical Insurance Plan: _____

Subscriber Name: _____ **Subscriber's Birth Date:** _____

Subscriber Number: _____ **Plan Code:** _____

Subscriber's Home Number: _____ **Work Number:** _____

Cell Number: _____

**********WE MUST HAVE A COPY OF YOUR MEDICAL AND DENTAL INSURANCE CARDS**********

DENTAL ASSOCIATES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 THIS PRACTICE MAY USE YOUR PERSONAL HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE SPECIFIC USES AND DISCLOSURES THAT WE INTEND TO MAKE ARE DESCRIBED IN OUR NOTICE OF INFORMATION PRACTICES. YOU HAVE THE RIGHT TO REVIEW THE NOTICE OF INFORMATION PRACTICES PRIOR TO SIGNING THIS CONSENT FORM. YOU MAY REQUEST RESTRICTIONS ON THE USES AND DISCLOSURES DESCRIBED IN THE NOTICE OF INFORMATION PRACTICES BY REQUESTING THE "RESTRICTION REQUEST" FORM. YOU MAY REVOKE THIS CONSENT AT ANY TIME BY SIGNING AND DATING THE REVOCATION FORM. ALL FORMS ARE AVAILABLE BY REQUEST.

CONSENT SECTION

I, _____, HEREBY CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. MY "PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION, COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER, OR A HEALTH CARE CLEARING HOUSE. THIS PROTECTED HEALTH INFORMATION RELATES TO MY PAST, PRESENT, AND FUTURE PHYSICAL AND/OR MENTAL HEALTH CONDITION.

I UNDERSTAND THAT I MAY REQUEST RESTRICTIONS ON THE USES AND DISCLOSURES OF MY HEALTH INFORMATION AT ANY TIME. I FURTHER UNDERSTAND THAT DENTAL ASSOCIATES IS NOT REQUIRED TO ACCEPT MY RESTRICTION REQUEST.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, IN WRITING, EXCEPT TO THE EXTENT THAT DENTAL ASSOCIATES HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT.

I UNDERSTAND THAT MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES TO REVIEW AND TO HAVE ANY QUESTIONS ANSWERED BEFORE SIGNING. DENTAL ASSOCIATES RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. A REVISED NOTICE MAY BE OBTAINED BY CONTACTING THE OFFICE.

_____ **DATE** _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____ **DATE** _____

DESCRIPTION OF PERSONAL REPRENSATATIVES AUTHORITY

PLEASE LIST ANYONE THAT YOU AUTHORIZE TO BRING YOU/YOUR CHILD TO DENTAL VISITS AND ALLOW TO MAKE DECISIONS OR DISCUSS DENTAL CARE.

1. _____
2. _____
3. _____
4. _____