WELCOME!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible.
If you have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name _____ (If child, parent/guardian name) _____
Last name *First name* *Initial*

Birthdate_____Sex____Age_____ Soc. Sec. #_____
Home Address_____City _____State_____Zip_____
Home Phone_____ Work Phone_____ Cell phone_____
E-Mail_____ Drivers License #_____

How did you hear about our practice? _____
Employer_____Occupation_____How long there? _____May we call?_____
Employer Address_____City _____State_____Zip_____

Spouse's Name (Or other parent/guardian)_____Soc. Sec. #_____
Spouse's Employer_____Occupation_____How long there? _____May we call?_____
Spouse's Employer Address_____City _____State_____Zip_____

If patient is a student: Name of school/college: _____City & State_____Full time or part time?_____

Primary Insurance:

Name of Insured _____
Birthdate_____Relationship to patient_____
Address (if different from patient)_____
Dental Insurance Co._____Phone_____
Social Security #_____ Subscriber ID #_____
Group, Contract or Local or union #_____

Additional Insurance:

Name of Insured _____
Birthdate_____Relationship to patient_____
Address (if different from patient)_____
Dental Insurance Co._____Phone_____
Social Security #_____ Subscriber ID #_____
Group, Contract or Local or union #_____

Copayments:

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check:

CIRCLE ONE: Visa MasterCard Discover Amex
Account#_____Expiration date_____Name on card_____
CVW# _____ ☐ Credit Card ☐ Debit Card ☐ ATM ☐ Voided check attached.

In Case of Emergency:

Name and City of primary care physician _____
Someone we may contact, not living with you: _____Phone #'s (home, work, cell)_____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I further authorize this office to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____Date_____
Patient or Responsible Party

Dental History

Patient Name_____ Age _____ Date _____

Reason for seeking care today: ___ Exam ___ Cleaning ___ Specific Problem _____
(Please describe)

Please check all that apply:

- ☐Toothache
- ☐Broken filling or tooth
- Sensitivity to:
  - ☐Cold
  - ☐Hot
  - ☐Sweets
  - ☐Chewing
- ☐Food catches
- ☐Loose teeth
- ☐Floss breaks easily or hurts
- ☐Bite or teeth have shifted
- ☐Often bite cheeks
- ☐Frequent dry mouth
- ☐Concerned about breath
- ☐Unhappy with previous dental work
- ☐Gums bleed
- ☐Gums tender
- ☐Growths, sores
- ☐Cold sores, fever blisters
- ☐Cracked, chapped lips
- ☐Bad taste in mouth
- ☐Sinus problems
- ☐Mouth breath - asleep or awake
- ☐Dry or strained eyes
- ☐Shoulder, neck or headaches
- ☐Clench or grind teeth
- ☐Jaw joint pain
- ☐Clicking or popping of joint.
- ☐Unable to open mouth wide
- ☐Jaw gets tired easily.
- ☐Hold things between teeth (Pipe, pencil, nails, pins)
- ☐Bite fingernails
- ☐Unusual habits with teeth
- ☐Wore braces
- ☐Previous gum treatment
- ☐Previous bite treatment

Would you like whiter teeth? _____

Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?

_____

Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?)

What happened? _____

Why did you leave your previous dentist?_____

Medical History

Physicians Name _____ City _____

Have you been hospitalized for any reason? Please describe:

_____

_____

Are you taking any medications or drugs (including nutritional supplements?) Please list:

_____

_____

_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other? _____

_____

Do you smoke? How much/day? _____

Pregnant? Due date _____ Are you nursing? _____

Are you seeing a physician now or planning to see one for any reason? Please explain:

_____

_____

Please check all that apply:

- ☐Previous injury to head or neck
- ☐Heart problem
- ☐Heart Attack
- ☐Angina, chest pain
- ☐Heart murmur,
- ☐Scarlet, rheumatic fever
- ☐Mitral valve prolapse
- ☐Irregular heartbeat
- ☐High or low blood pressure
- ☐Pacemaker
- ☐Artificial joint
- ☐Diabetes
- ☐HIV or AIDS
- ☐Kidney problem
- ☐Liver problem, jaundice
- ☐Cirrhosis, Hepatitis
- ☐Cancer
- ☐Radiation, chemo.
- ☐Respiratory problem
- ☐Bloody, persistent cough
- ☐Asthma, Emphysema.
- ☐Anemia
- ☐Sickle cell
- ☐Digestive problem, ulcer
- ☐Thyroid disease
- ☐Glaucoma
- ☐Bleed or bruise easily
- ☐Stroke
- ☐Epilepsy or Seizures
- ☐Parkinson's
- ☐Alzheimer's
- ☐Back problem
- ☐Hives, rash, Herpes
- ☐Dry eyes
- ☐Shortness of breath
- ☐Snoring, sleep apnea
- ☐Easily winded
- ☐No energy
- ☐Fainting or dizzy
- ☐Unexplained weight loss
- ☐Chewing tobacco
- ☐Drug or alcohol addiction
- ☐2 or more social drinks/day
- ☐Anxiety or nervous disorder
- ☐Insomnia
- ☐Contact lenses

Any other illnesses not checked above:_____.

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ☐Yes ☐No

Please rate your daily stress level: 1-10 (1 = lowest stress).

__Overworked, busy, pressured __Worried, frustrated __ Get upset or snap easily __Insomnia, depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian) _____ Date_____

Dentist' Signature_____ Date_____

HIPAA NOTICE OF PRIVATE PRACTICES

RELEASE FORM

Patient's Name _____ Date of Birth _____

By now you have probably signed the HIPAA form many times. It is a federal requirement that we keep a HIPAA notice in your chart.

HIPAA (The Insurance Portability and Accountability Act) basically says that your personal health information must be kept confidential.

1. We can use your health information to coordinate treatment with other health care providers.
2. We can use your health information with insurance companies for payment.
3. Your health information can be used for "common sense" uses like calling you for an appointment.
4. You have the right to inspect your personal health information
5. You have the right to restrict the use of your health information

This information may be released to:

_____My spouse _____My children ____My parents ____Other

_____Don't release this information to anyone

If "other", please inform of their name and address

_____

_____

EMAILING OF X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email X-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that X-rays might need to be emailed to other specialists. I give my permission for this service.

I authorize the release of information including diagnosis, records, examination rendered to me and insurance claims information.

Signature: _____ Date: _____

If you have any questions about HIPAA and how your information is used, please feel free to ask about our HIPAA policy folder.

DENTAL DEVOTION
Cosmetic, Implant, and Family Dentistry

Information on Dental Insurances

PPO Insurance: As a courtesy to our valued patients, our office will directly submit claims to PPO insurances. We do ask our patients to be prepared to make payment at the time services are rendered. Unlike medical insurances, dental insurances are designed to assist you with dental expenses. Your employer chooses plans based on costs and benefits. These plans typically have percentage co-payments and deductibles as opposed to flat fee (i.e. $10, $20). Bear in mind that our relationship is with you and not with your insurance company. We have no leverage or influence on benefit determination, covered procedures or payments.

Fees: As a provider for most PPO insurances, we charge fees set by your PPO plan. We do not charge above the allowed fee schedule.

Eligibility: As a courtesy, we contact your insurance company to verify the specifics of your plan. This does not guarantee any of the benefits. Feel free to bring your insurance card with you and we will be happy to assist you in understanding your plan. You can always contact your insurance company directly with any questions.

Co-payments: Keep in mind that the co-payment is only an estimate. Your co-payment, if any, is due at the time services are rendered. Since the co-payment is an estimate, final financial responsibility is determined once the insurance payment has been posted to your account. The EOBs (explanation of benefit) used to calculate your balance will also be send to you directly from your insurance company. In the event that the co-payment was underestimated, a statement will be sent for any balance remaining and if overestimated, your account will be credited accordingly.

Secondary PPO Insurance: Secondary insurance claims will be submitted for our patients. Please understand that the secondary insurance only pays parts of your balance remaining depending on how much the primary insurance chooses to pay. In all cases, there will be a remaining portion that will be patient's responsibility. Since this amount is nearly impossible to calculate at the time that services are rendered, we ask patients to pay part of what the primary insurance balance indicates. Once the payment is received from both insurance companies, there may be a balance due or a credit made to the account. We will then send you a statement or credit your account accordingly.

Our office will make every attempt to collect payment from your insurance company. In the event that your insurance does not pay within 90 days of the date of service, the patient will be responsible for the balance in full and can submit the claim for reimbursement to the insurance company.

I have read and understand the above information.

Patient/Guardian:_____ Date:_____

DENTAL DEVOTION
Cosmetic, Implant, and Family Dentistry

OFFICE POLICIES

SCHEDULING AND CANCELLATIONS

Because we value the time spent with our patients, appointments that you make are solely for you and the doctor. Please give our office the consideration to fill your reservation should you need to cancel.

- Please allow our office a notice of at least 48 business hours for any cancellations. Please note that Saturdays and Sundays do not constitute business days. Any notice less than 24 business hours will be subject to a $60.00 per hour broken appointment fee.
- The office will ask for half of the co pay or fee when scheduling appointments longer than an hour and for procedures that include lab work. This will ensure reservation of the time slot for you and the doctor.

_____
Initials

For your scheduled appointments, you will be contacted a few days in advance via text, email, and/or phone call. Please make sure to communicate with us that you will be coming to your appointment in a timely manner. If you wish not to be contacted via text or email, please inform us as well. If no confirmation is received, we may offer that appointment to our other valued patients and your appointment will need to be rescheduled.

TREATMENT PLAN

Co-payments are due at time of service. As stated above, half of your co-payment will be requested when scheduling appointments longer than an hour and for procedures that include lab work (i.e. Crowns, Bridges, implants, partial and full dentures, night guards, etc.)

_____
Initials

PARKING VALIDATION

Our office does provide a one-hour validation to patients on the day of their appointment. The garage is located below the building and accessed through 11th Street. Please bring your ticket with you for validation.

TYPES OF PAYMENT ACCEPTED

Personal checks are not accepted. Cash and major credit cards, American Express, Visa, MasterCard, and Discover, are accepted. We also offer no interest payment plans from Care Credit only for patients without dental insurance.

DUPLICATION OF RECORDS

Please allow our office 2-3 business days to email you the records and/or x-rays. We are required by law to keep your records on file.

FINANCIAL AGREEMENT

I agree that all the information on patient registration form is complete and accurate. I acknowledge that all charges incurred in this office are my responsibility. If for any reason my insurance should fail to pay for any charges billed, I agree to pay for the services upon notification by a representative by this office. I may then need to collect my benefits directly from the insurance carrier. I understand that if my account remains unpaid by me for a period of 60 days, it may be referred to the collection agency.

_____ _____
Patient/Guardian Date