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## Welcome to our Practice

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**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

**Preferred method of contact: ***

☐ Text ☐ Email ☐ Cell ☐ Home ☐ Work

**Please enter Employer and Occupation**

_____

_____

Whom may we thank for referring you to our practice?

_____

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

_____

_____

## Responsible Party Information:

### Please enter information for the person financially responsible for the account

**Please indicate Responsible Party ***

◯ I am financially responsible for this account--Skip this section and continue to the next section.

◯ Other--Please fill out information below

**The following is for:** ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

**Name:** _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

**Title:** _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ 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

**Primary Dental Insurance Company Phone Number:**

_____

_____

**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.**

### Secondary 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

**Secondary 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

Thank you for selecting us to help take care of your dental health. We are committed to having your treatment be a positive experience. It is our belief that all people who entrust their oral health to us want and deserve the finest dental care that we are capable of providing. Please understand your financial obligations are considered part of your treatment. Our purpose in providing you this financial information is to acquaint you with our policy for our mutual benefit. We will give you an estimate of costs required in advance of treatment so that you can come prepared for each visit. Please read the following and sign before being seen.

1. Full payment is due at the time of service. A 5% cash courtesy will be given when services are paid for in full on the day of treatment by cash or check for services totaling $1000 or more. This option is not available to patients who carry dental insurance through Delta Dental. Other payment options include credit card Visa/MasterCard/American Express or Discover) or third-party financing with prior approval through Wells Fargo Bank.

2. The following applies to those patients with insurance:
- If at your first appointment we are unable to verify your dental insurance or cannot obtain a list of benefits, full payment is due at the time services are rendered.
- Patients are to pay their deductible and estimated co-payments at the time treatment is rendered.
- We attempt to verify coverage on your behalf. However, the information that we receive is not a guarantee of benefits or payment by your plan. We sincerely encourage you to contact your insurance carrier to review and be aware of the benefits available to you.

ASSIGNMENT OF BENEFITS: I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes the Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

3. Minor Patients: Must be accompanied by a parent or guardian for all appointments unless a written consent is provided. The adult accompanying the minor is responsible for payment.

4. Past Due Account Fees: There is a $25 fee charged on all returned checks. Account balances older than 30 days are subject to a finance charge of 1.5% per month plus a monthly billing fee of $5.00. Any balance older than 90 days will be forwarded to "Collections" and subject to additional collection fees, including, but not limited to, attorney's fees, court costs, etc.

5 Consent for Treatment: I hereby give consent to the dentist and/or his/her designee(s) for the performance of any diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I further authorize the performance of all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me. I understand that no guarantee or assurances have been made as to the results that may be obtained.

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

## Missed Appointment and Cancellation Policy

Your scheduled appointment has been reserved exclusively for you. Please notify our office at least 48 hours before your scheduled appointment time or a $75 fee will be charged that is not covered by insurance. Payment of this fee may be required prior to reserving subsequent appointments.

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

## 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.**

## Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

**Name of person filling out this form: ***

_____

_____

**Relationship to patient: ***

☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other