Today's date:______________________ Date of Birth:___________________

First name____________________________ Last Name____________________________

Email Address__________________________________ Social Security Number ____________________

Street Address:____
City:____________________________ State:____________ ZIP________________

Home Phone:_________________________ Cell Phone______________________
Emergency Contact
Name____
Relation to you ____
Phone Number____

Question		
Are you under the care of a physician now?	Yes	No
Are you in good health?	Yes	No
Have there been any changes in your health in the past year?	Yes	No

If Yes, what condition is being treated? ____

____

Have you had a serious illness,operation or been hospitalized in the past 5 years? Yes | No

If yes, what was the illness or problem? ____

____

Name of Medical Doctor ____
Address____
Phone Number____
Date of last visit _______________________________

Preferred Pharmacy____
Street Address____
City,State & ZIP ____
Phone Number ____

1. Joint Replacement: Have you had an orthopedic joint (hip, shoulder, knee, finer, elbow etc) replacement? Yes | No

Date done____

If YES, have you been told that you need to take an antibiotic premed before your dental appointment? Yes | No

Question		
2. Are you currently taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast or Evista?	Yes	No
3. Do you take a daily Aspirin?	Yes	No
4. Do you take blood thinner, such as Eliquis, Xarelto, Coumadin, Wafarin, Plavix, Clopidogrel, Brilinta, Ticagrelor, Effient, Prasugrel?	Yes	No

Name____

Allergies- are you allergic to or have you had a reaction to:

Item		
Aspirin	Yes	No
Codeine	Yes	No
Ibuprofen	Yes	No
Iodine	Yes	No
Latex	Yes	No
Local Anesthestic (Dental)	Yes	No
Metals	Yes	No
NSAID's	Yes	No
Nut Allergy	Yes	No
Penicillin	Yes	No
Amoxicillin	Yes	No
Red Dye	Yes	No
Sulfa	Yes	No
Foods	Yes	No

Other: ____

Do you have or have had any of the following:

Condition		
AIDS/HIV	Yes	No
ADD/ADHD	Yes	No
Autism	Yes	No
Aspergers	Yes	No
Alzeheimers	Yes	No
Dementia	Yes	No
Anemia	Yes	No
Anaphylaxis	Yes	No

to what__________________

Condition		
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Back Problems	Yes	No
COPD	Yes	No
Emphysema	Yes	No
Tuberculosis (TB)	Yes	No
Epilepsy	Yes	No
GI Troubles	Yes	No
Stomach Ulcers	Yes	No
Glaucoma	Yes	No
Headaches	Yes	No
Hearing Impaired	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Osteoporosis	Yes	No
Osteopenia	Yes	No
Parkinsons	Yes	No
Sexually Transmitted Disease	Yes	No
Sickle Cell Disease	Yes	No
Sickle Cell Trait	Yes	No
Sleep Apnea	Yes	No
Uses CPAP machine	Yes	No
Thyroid Disease	Yes	No

Cancer	Yes	No

If yes, what type____________________

When (date)____________________

Condition		
Radiation Treatment	Yes	No
Chemotherapy	Yes	No
Leukemia	Yes	No
Tumors	Yes	No

If yes, what type____________________

When (date)____________________

Heart/Stroke

Condition		
Congestive Heart Disorder	Yes	No
Congenital Heart Disorder	Yes	No
Heart Attack	Yes	No

If yes, when (date)________________

Heart Surgery	Yes	No

If yes, what type____________________

When (date)____________________

Cardiac Pacemaker	Yes	No

If yes, when (date)________________

Condition		
Heart Murmur	Yes	No
Mitral Valve Prolapse(MVP)	Yes	No
Artifical heart valves	Yes	No
Rheumatic Fever	Yes	No
Angina	Yes	No
AFIB	Yes	No
Stroke	Yes	No

If yes, when (date)________________

Question		
Do you smoke?	Yes	No
Do you vape?	Yes	No
Do you chew tobacco?	Yes	No

Name____

Kidney Disease	Yes	No
Renal Dialysys	Yes	No

If yes, when treatment start_______________________

Autoimmune Disease

Hashimotto's	Yes	No
Gout	Yes	No
Rheumatoid Arthritis	Yes	No
Lupus	Yes	No

Other____

History of Drug Abuse	Yes	No
History of Alcohol Abuse	Yes	No
Recreational Drug Usage	Yes	No

Liver Disease	Yes	No
Hepatitis A	Yes	No
Hepatitis B	Yes	No
Hepatitis C	Yes	No
If yes, has it been treated	Yes	No

Date treated ______________________

Bleeding Disorders

Hemophilia	Yes	No
Blood transfusion	Yes	No

If yes, date received _________________

Factor 5 Blood disorder	Yes	No
Any other blood disorder	Yes	No

If yes, please explain ________________

History of blood clots	Yes	No

Diabetes	Yes	No

If Yes, Type 1 or Type 2

A1C _________________ Date_________________

Hypoglycemia	Yes	No

Are you pregnant?	Yes	No

If yes, due date ______________________

Medications or Supplements Currently Taking

Name	Dose	Frequency	Reason for Taking

Insurance Information

Employment Status: Full Time ______ Part Time ______ Retired ______ Not ______

Marital Status: Married ______ Divorced ______ Widow ______ Single ______
Seperated ______

Responsible party for your account: Self ______ Father ______ Mother ______ Spouse ______
Other ______________

Responsible Party *(if not patient)* Name ____
First *Middle Initial* *Last*

Social Security Number ______________ Date of Birth __________ Phone ______________

____
Address *City* *State* *Zip*

Employer Name ____ Phone ______________

____
Address *City* *State* *Zip*

PRIMARY INSURANCE

Insurance Company Name ____

Insurance Address ____
Address *City* *State* *Zip*

Subscriber Name ______________________ Date of Birth ______________

Subscriber Gender Male ______ Female ______ Other ______________

Subscriber ID ______________________ Group Number ______________

Subscriber Address ____
Address *City* *State* *Zip*

SECONDARY INSURANCE (If Any)

Insurance Company Name ____

Insurance Address ____
Address *City* *State* *Zip*

Subscriber Name ______________________ **Date of Birth** ______________

Subscriber Gender Male ______ Female ______ Other ______________

Subscriber ID ______________________ **Group Number** ______________

Subscriber Address ____
Address *City* *State* *Zip*

NOTIFICATION AND AUTHORIZATION FOR USE OF IDENTIFYING HEALTH INFORMATION

Patient Name: ______________________________________ Date of Birth: ____________

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Your insurance company(s), third-party payors, other healthcare providers and persons you indicate to have access to your appointment, account or clinical treatment information.

   May we phone, email, or send a text to you to confirm appointments? YES NO
   May we leave a message on your answering machine at home or on your cell phone? YES NO

2. The purpose for the release is at the request of the individual.
3. There is no expiration date for this authorization unless specifically requested by the patient.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you are covered by a dental insurance plan, you will be required to file your own insurance claims as this office will not be able to release any information to them.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

PATIENT or Guardian Signature________________________________Date: ________________

If you are signing as a personal representative or guardian of the patient, describe your relationship to the patient and/or the source of your authority to sign this form (i.e. parent, POA,etc.):

Print Name: ____

Source of Authority: ____

If there is anyone you would like to have access to your account or appointment information (including your spouse), please list their information below:

Name, Relationship and Phone Number of those who may have access to my appointment, account, and clinical treatment information:

_________________________________ _________________________________

☐ **I DECLINE TO SIGN THIS FORM**

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 _______
Other (please describe) ____________ Signature of Privacy Officer__________________________

Appointment Cancellation Policy

In order to be respectful of the dental needs of other patients, please be courteous and call our office promptly if you are unable to keep an appointment. Our messages are checked around the clock, even on the weekends. We require at least a 24-hour notice for any cancelled appointment without being charged a $40 Late Cancellation Fee. The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

Cancellations less than 24 hours in advance is referred to as a Broken Appointment. We typically cannot refill these appointments on short notice. Appointments are in high demand. Early cancellations give our staff enough time to fill the appointment that was being held for you.

Patients may be dismissed from the practice after 3 Broken appointments.

Due to the high demand for our Evening and Saturday appointments, we have implemented a policy specifically for them. If a patient no shows/last minute cancels for an Evening or Saturday appointment, they will NOT be rescheduled for another Evening or Saturday appointment. The patient will have the option to be placed on a short call list. This is a list of patients to call when an "at the last minute" appointment opens up. There is no guarantee that patients will be called off of the short call list.

We understand that there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. This will be taken into consideration when assessing the late cancellation fee.

I have read and agree to the above policy.

Patient Name (Printed): ___________________________________Date: _______________

Signature: ____

Relationship to Patient: ____________________________________

Financial Policy and Agreement

In order to keep our billing costs and ultimately our prices under control, payment for all dental services is required on the day services are rendered. Those with dental insurance are expected to pay their estimated co-pay and deductibles the same day services are rendered. We also offer CARECREDIT, which is a financing option/extended payment plan that is available only for healthcare expenses. Monthly statements will be mailed to all patients with outstanding balances. Accounts that are 90 days past due will incur a finance charge of 15% per annum.

We accept Cash, Check, Visa, Discover, Mastercard and American Express credit cards.

A $40.00 return check fee will be applied to your account, if applicable.

Insurance Information:

If you have dental insurance, as a courtesy to our patients, we will contact your insurance company or employer for a breakdown of your benefit plan. We will also submit any claims to your insurance company free of charge. You will need to present your insurance card to us on your first visit of every calendar year to ensure all information on file is correct. This will allow us to help you maximize your dental benefits.

We will attempt to collect payment from your insurance company up to three months after treatment was performed. Starting month four, we will ask for your help. You are the person paying the premiums and sometimes you or your employer have to demand action from the insurance company.

If after six months, your insurance company does not settle the bill, then it becomes the patient’s responsibility. You will be expected to pay your balance and then get reimbursed directly from your insurance company.

All of our doctors will diagnose treatment based on your dental health NOT your insurance coverage.

Treatment Plans:

As a courtesy to our patients, we will provide patients with a detailed treatment plan at your appointment. These plans will include what treatment the Doctor has recommended, and the fee(s)associated with that treatment. If you have dental insurance, this will include our fee, what insurance is estimated to cover, and what your out-of-pocket expense is estimated to be. We calculate this estimate from the information your dental insurance provides to us from your benefit plan. The estimated portion not covered by your insurance will be due at the time of service. This amount is only an estimate and could end up being higher or lower than what was originally estimated.   There may also be instances in which your insurance will not cover any portion of the recommended treatment. In this situation it will be the patient's responsibility to pay the treatment fees.

I have read and agree to the above policy.

Patient Name (Printed): ___________________________________ Date: _________________

Signature:____

Relationship to Patient: ____________________________________