Deerflat Dental

Patient Information

Name_____ DOB_____ M ____ F ____
Address_____ City_____ State_____ Zip_____
Status M S D W Home phone_____ Cell phone_____
SSN_____ DL#_____
E-mail_____
Emergency Contact_____ Relationship_____ Phone_____
Referred by: Mailer___ Insurance Co.__ Website__ Patient_____

Responsible Party

Name_____ DOB _____ Relationship to patient_____
Address_____ City _____ State ____ Zip _____
Phone # Home_____ Mobile_____ Work_____
SSN _____ Driver's License #_____Employer_____

Please have your insurance card ready so we can make a copy

Insurance Information

Subscriber_____ Relationship to patient_____
Subscribers DOB_____ Subscribers SSN_____ Employer_____
Insurance Company_____ Group #_____
Ins. Co Address_____ City_____ State_____
Phone number _____

Secondary Insurance

Subscriber_____ Relationship to patient_____
Subscribers DOB_____ Subscribers SSN_____ Employer_____
Insurance Company_____ Group #_____
Ins. Co Address_____ City_____ State_____
Phone number _____

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Patient Medical and Dental History

Patient Name:_____

DOB: __/__/____

Medical History

	YES	NO
1. Are you under medical treatment now?	○	○
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?	○	○
4. Pre-medication needed for dental treatment?	○	○
5. Do you use tobacco?	○	○
6. Do you use controlled substances?	○	○
7. Women Only:		
a. Are you pregnant?	○	○
b. Are you nursing?	○	○
c. Are you taking oral contraceptives?	○	○

8. Are you allergic to any of the following:

	YES	NO
Local Anethetics (i.e. Novocain)	○	○
Penicillin or other antiboitics	○	○
Sulfa Drugs	○	○
Sedatives	○	○
Iodine	○	○
Asprin	○	○
Any Metal (i.e. nickel,mercury, ect)	○	○
Latex Rubber	○	○

Other (please list): _____

9. Do you have any of the following:

	YES	NO
Acid Reflux/GERD	○	○
Anemia	○	○
Angina/Chest Pains or Tightness	○	○
Asthma	○	○
Arthritis	○	○
Cancer	○	○
Type: Year(s):		
Cardiac Pacemaker	○	○
Diabetes	○	○
Easily Winded	○	○
Emphysema/COPD	○	○
Epilepsy/Convulsions	○	○
Fainting/Dizzy Spells	○	○
Glaucoma	○	○
Hay Fever/Seasonal Allergies	○	○
Heart Attack	○	○
Heart Murmur	○	○
Other Heart Complications: _____	○	○
Hepatitis	○	○
High Blood Pressure	○	○

	YES	NO
HIV/AIDS	○	○
Hypoglycemia	○	○
Kidney Disease	○	○
Low Blood Pressure	○	○
Liver Disease	○	○
Joint Replacement	○	○
Which: Year:		
Mitral Valve Prolaspe	○	○
Osteopenia/Osteoporosis	○	○
Recent Weight Loss	○	○
Rheumatic Fever/Scarlet Fever	○	○
Sexually Transmitted Disease	○	○
Sinus Complications/Trouble	○	○
Sleep Apnea	○	○
Stomach Troubles/ Ulcers	○	○
Stroke	○	○
Swollen Limbs/Edema	○	○
Thyroid Problems	○	○
Tuberculosis	○	○

Other? Please explain: _____

10. Are you Currently taking any medications? If Yes, please list. _____

_____

11. Medical Physician: _____ Office phone:_____ Date of last exam:_____

Patient Dental History

	YES	NO
1. Have you had head, neck or jaw injuries?	○	○
2. Do you experience clicking, pain, difficulty opening/closing or chewing?	○	○
3. Do you have frequent headaches?	○	○
4. Do you clench or grind your teeth?	○	○
5. Do you wear dentures or partials?	○	○

	YES	NO
6. Have you had a difficult extraction in the past?	○	○
7. Have you had prolonged bleeding following an extraction?	○	○
8. Have you had orthodontic treatment?	○	○

9. How do you feel about your smile?

_____

I certify that I have read and understand the above information. I understand th importance of a truthful health history and that my dentist and his/her staff will rely on this informatin for treating me.

Patient Name _____

Patient/ Guardian Signature _____ Date_____

Financial Policy

We are committed to providing you with the highest quality dental care. If you have dental insurance, we will be happy to answer any questions relating to your insurance and bill on your behalf. However, we need your assistance and your understanding of our payment policy.

As dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, acceptance of insurance assignments does not absolve the patient of full responsibility for charges for treatment rendered. If we fail to receive a response from your insurance company within 60 days, or if your claim is denied payment, you will be responsible for payment of the account in full.

Please understand that not all services are a covered benefit in all insurance contracts and no insurance company guarantees payment on claims submitted. Therefore, if you have insurance coverage, you will be required to pay and **ESTIMATED PORTION** of the bill at the time services are rendered. (This amount varies depending on your insurance coverage and the maximum amount of coverage remaining for the year.) Once your insurance pays, your account will be reconciled and you will be billed for the balance or sent a check for the overpayment.

- If you are a private pay patient, non-insured, payment of services is required at the time services are rendered.
- We offer six payment options: **Cash, Check, MasterCard, Visa, Discover, or Care Credit.**
- Any returned checks are subject to a $50.00 or 19% of check, whichever amount is higher, service charge.
- Any account balance over 60 days old may be subject to a 15% monthly financial charge
- Unpaid balances are subject to action by a collection agency. Those balances may have an additional fee added to them of up to 35% for attorney fees, court cost and etc.

We realize temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our office promptly for the assistance in the management of your account.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help you.

Appointment policy

We make every effort possible to get each patient in to see the doctor and /or hygienist in a timely manner. We ask that you help us by arriving promptly to your scheduled appointment time. If you are unable to utilize the appointment time set aside for you and have to cancel/reschedule your appointment, we ask that you contact us 24 hours before the scheduled appointment time to do so. We reserve the right to charge $75.00 per appointment that is cancelled or rescheduled without at least 24 hours communication.

_____ _____

Patient/Guardian Signature Date

Notice of HIPPA Privacy Practices Acknowledgement

I Understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain Payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____