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. ____________________

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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?		

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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

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose Protected Health Information (PHI).

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

The terms of the notice may change, if so, you will be notified at your next visit to update your signature.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this contract.

May we phone, email or send a text to you regarding appointments? Yes No

May we leave a message on your voice mail at home or cell phone? Yes No

May we discuss your dental needs/conditions with any family members? Yes No
If YES, please name the members allowed:

____________________ ____________________

____________________ ____________________

Signature:____________________ Date: ____________

Print Name: ____________________Relationship to patient: ____________