Patient Name

First Name	Last Name

Patient Information

Contact

Middle Name	Preferred Name	Date of Birth	SSN
Gender	Married	Work Phone	Wireless Phone
Wireless Carrier	Email	Preferred Contact Method	
Preferred Contact Method for Confirmations		Preferred Contact Method for Recall	
Student Status if dependent over 19 (For Insurance)			

Address Information

Address	City	State	Zip

Insurance

Insurance Policy 1

Relationship to Subscriber		Subscriber Name	Subscriber/Member ID
Insurance Company	Insurance Phone	Employer Name	Group Name
Group ID			

Please present insurance card to receptionist

Insurance Policy 2 (If applicable)

Your relationship to subscriber		Subscriber Name	Subscriber/Member ID
Insurance Company	Insurance Phone	Employer Name	Group Name
Group ID			

Financial Agreement

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our staff members for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments with the understanding that any uninsured portion that is not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

* Personal checks that are returned due to "insufficient funds" are subject to a $25.00 service fee.

Minors

Adult patients are responsible for full payment at the time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

I hereby authorize payment directly to this practice of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the dental treatment for the patient named below. The information on the page and the dental / medical histories are correct to the best of my knowledge. I grant the right to this practice to release the patient's dental and / or medical histories and other information about the patient's dental treatment to third-party payers and / or other health professionals.

Signature	
Date	Patient Name

Privacy Policies

Notice of Privacy Policies

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature of Patient, Parent, or Guardian	Date

Medical History

Information

Name of Medical Doctor	City/State	Emergency Contact
Emergency Contact's Phone	Relationship	
List all medications you are now taking		

Allergies

Are you allergic to any of the following?

Anesthetic	Aspirin	Codeine	Ibuprofen
Iodine	Latex	Penicillin	Sulfa

Medical History

Asthma	Bleeding Problems	Cancer	Diabetes
Heart Murmur	Heart Trouble	High Blood Pressure	Joint Replacement
Kidney Disease	Liver Disease	Pregnancy	Psychiatric Treatment
Sinus Trouble	Stroke	Ulcers	Rheumatic Fever

Medical History Continued

Tobacco use	Unusual reaction to dental injections	Reason for today's visit

Are you in pain?	Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old?	Do you have BiteWing x-rays that are less than 1 year old?

Name of former dentist	City/State
Date of last cleaning and exam	

Patient Name

First Name	Last Name

Patient Information

Contact

Please fill out the information below

Preferred Name	Address	City	State
Zip	Gender	Primary Phone	Other Phone
Date of Birth		Email	

Other

How did you hear about our office?	Reason for consultation?
Date of last cleaning	

Insurance Information

Guardian

Guardian First Name	Guardian Last Name	Address	City
State	Zip	Mobile Phone	Work Phone
Date of Birth		Email	

Insurance (if applicable)

Company	Phone	Subscriber/Member ID

Medical Information

Sleep/Airway Issues

Does the patient tend to be a mouthbreather?	Does the patient snore at night?	Does the patient seem rested in the morning?	Is the patient often sleepy during the day?
Has the patient seen an ear, nose or throat specialist?		Is the patient using a sleep apnea device?	

Medical History

Acid Reflux	ADHD/ADD	AIDS/HIV	Anemia
Arthritis	Asthma	Autism	Bone Disorders
Cancer	Cerebral Palsy	Chest Pain	Chronic Neck Pain
Cold Sores/Herpes	Diabetes	Down Syndrome	Endocrine Problems
Emotional Disorders	Epilepsy	Headaches	Heart Condition
Hepatitis	Ear Pain	Immune Problems	Kidney Problems
Low Blood Pressure	Muscular Disorders	Nervous Disorders	Organ Transplant
Osteoporosis	Prolonged Bleeding	Rheumatic Fever	Scoliosis
Seizures	Sinus Problems	Tuberculosis	

Dental History

Clicking of Jaw	Jaw Pain	Painful Chewing	Periodontal Problems
TMJ Problems	Do your gums bleed when you brush?	Is the patient seeing any other dental specialists?	Any dental restorations needing to be completed?
Have there ever been any injuries to the face, mouth or chin?	Have you ever lost or chipped any teeth?	Do you have any pain or soreness around your face, neck or back?	Is any part of your mouth sensitive to temperature or pressure?
Is the patient currently pregnant?	Have adenoids been removed?	Have tonsils been removed?	Currently taking any medications?
Are antibiotics necessary prior to treatment?	Allergies?	Any diseases or problems not mentioned above?	

Patient Name

First Name	Last Name

Patient Registration

Contact

Preferred Name	Email	Phone	Date of Birth
Address	Marital Status	Employer	Employer Address
Where and when are the best times to contact you?		Whom may we thank for referring you?	
Other family members seen by us		Last Dental Visit	Last Dentist Seen

Spouse Information

Name	Date of Birth	Employed?	Phone
Email			

Insurance Information

Insurance (if applicable)

Do you have Insurance?	Company Name	Company Address	Company Phone
Group ID (Plan, Local, or Policy)			

Second Insurance (if applicable)

Only fill out if you have a secondary insrance plan

Company Name	Company Address	Company Phone
Group ID (Plan, Local, or Policy)	Insured's Name and Relationship	
Insured Birth Date	Insured's Employer and Employer Address	

Signature

If this office accepts my insurance, I understand, that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination required, to my insurance company.

Signature of Patient, Parent, or Guardian	Date

Medical History

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill this form out completely so that we can provide optimal care for you.

About You Medically

Do you have a personal physician?	Date of Last Visit	Are you currently under the care of a physician?	Art you taking any Prescription/over-the-counter or herbal supplemental drugs?
Do you take, or have you taken, Phen-Fen or Redux?		Do you smoke or use tobacco in any other form?	

Medical History

AIDS/HIV Positive	Anemia	Asthma	Artificial Heart Valve
Artificial Joint	Blood Disease	Blood Transfusion	Cancer
Congenital Heart Disorder	Cortisone Medicine	Diabetes	Easily Winded
Emphysema	Epilepsy or Seizures	Excessive Bleeding	Heart Attack/Failure
Heart Pacemaker	Heart Murmur	Heart Trouble/Disorder	Hepatitis A
Hepatitis B or C	Hemophilia	High Blood Pressure	Leukemia
Liver Disease	Mitral Valve Prolapse	Osteoporosis	Pain in Jaw Joints
Radiation Treatments	Renal Dialysis	Stroke	Thyroid Disease

Tonsillitis	Tuberculosis	Have you ever had any serious illness not listed above?

Women: Are you...

Pregnant/Trying to get pregnant	Nursing?	Taking Oral Contraceptives?

Dental History

Allergies?	Why have you come to the dentist today?	Do you require antibiotics before treatment?

Are you currently in pain?	Have you ever had a serious / difficult problem associated with any previous dental work?	Have you ever had gum treatment?

Your current dental health is	Do your gums bleed?	Do you like your smile?
How many times a week do you floss?	How many times a week do you brush?	
What type of bristles does your toothbrush have?	Is any part of your mouth sensitive to temperature or pressure?	

Signature

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

Signature of Patient, Parent, or Guardian	Date

Step 4

Step 5

Allergies

Do you have any allergies?

Anesthetic	Aspirin	Codeine	Ibuprofen
Iodine	Latex	Penicillin	Sulfa

Patient Name

First Name	Last Name

Patient Registration

Contact

Preferred Name	Email	Phone	Date of Birth
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Signature of Patient, Parent, or Guardian	Date

Step 4

Step 5

Allergies

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Patient Name

First Name	Last Name

Patient HIPAA Consent Form

Patient HIPAA Consent Form

I understand that as part of my healthcare, this originates and maintains health records describing my health history symptoms examination and test, results, diagnoses, treatment and any plans for future care of treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communicating among many health professionals who contribute to my care
- A source of information for applying my diagnoses and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professions

I understand and have been provided with Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent, I understand that the organization reserves the right to change their notice and practices and prior to its implementation mail a copy of any use of my health information may be used and or disclosed to carry out treatment, payment, of healthcare operations and that the organization is not required to agree to the restrictions requested, I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Full Name (Print)			
Signed			
Date		Relationship to Patient	
Persons that you will allow to have access to your personal dental information and dental appointment information:		Name	Relationship
Contact Number	Name	Relationship	Contact Number

40th & Dodge Family Dentistry - 1/22/2024

Patient Name

First Name	Last Name

Payment Policies

40th Dodge Family Dentistry Payment Policies

Patient responsible for fees: I understand that responsibility for payment for Dental Services provided in this office for myself and/or my dependents is mine. Unless prior arrangements are made in-writing, accounts are to be paid within 30 days of the date on which services were provided.

Insurance is filed as a courtesy: I understand that my dental insurance is a contract between me and the insurance carrier, not between the insurance carrier and the doctor and that I am still fully responsible for all dental fees. I hereby authorize that the payment from any insurance company due to me be paid directly to the working practice. In the event of default of payment, the patient or party responsible for fees agree to pay; all cost of suit, collection and attorney fees.

Patient is responsible for paying their estimated out of pocket share of cost at the time of the appointment. Please be aware of your coverage.

All major dental work requires 50% of payment at the beginning of the procedure and the remaining 50% at the time of completion, i.e.; Root Canals, Implants, Bridges, Crowns, Extractions and Partial/Complete Dentures.

I authorize the Dentist to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk.

A minimum notice of cancellation 24 hours prior to your is required or a cancellation fee of $25.00 may occur. In the event a 3rd confirmed appointment is missed; a $50.00 fee will be charged and the patient may become inactive in our system. Patient must confirm appointment 24 hours prior to the appointment. If the appointment is not confirmed within 24 hours, appointment may be cancelled and patient may be rescheduled.

By signing below, I consent to the dental treatment provided by this practice. I consent to agreement with all payment and reimbursement policies as stated above. I agree to assign all insurance benefits paid to me for services provided to the rendering provider.	Full Name (Print)
Signed	
Date	