

Douglas Family Dentistry
Where Healthy, Beautiful Smiles Begin Date: _____
Welcome to our Practice!

PATIENT INFORMATION:

Last Name: _____ First Name: _____, E-mail: _____,

Preferred to be called: _____, Mailing Address: _____

City, State, Zip: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____,

SS#: _____, Sex: M F Occupation: _____

Employer: _____, Address, City State, Zip _____

Emergency Contact Name: _____ Phone # : _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____, City, State, Zip: _____

Spouse's Employer: _____ Address, City, State, Zip: _____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you: Phone number: _____

How did you hear about our office? Please check: Internet Search Patient referral (who) _____ Website _____
 Yellow Pages Phx Mag Other(please explain) _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____ SS#: _____ Birth date: _____

Group# or Policy # _____ Employer _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. (Provider's Name) of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: _____ Patient's Signature: _____

CONSENT:

I hereby authorize Douglas Family Dentistry to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Douglas Family Dentistry to make a thorough diagnosis of the patient's dental needs. I also authorize Douglas Family Dentistry to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Douglas Family Dentistry and your insurance company. I fully understand that it is my responsibility for all dental treatment in regards of insurance coverage.

Patient Signature: _____ Date: _____ Dr. Signature: _____

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

{Signature of Patient and/or Guardian}

{Date} _____

(Relationship to Patient) Self

or Other: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement at time of service
- Other (Please specify) _____

Our Financial Philosophy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits.

Regarding Insurance

We file insurance claims for all patients with insurance benefits. Reimbursement checks from your insurance will come directly to the patient, **not to our office**. We very much appreciate your payment in full upon receipt of services.

WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA, AMERICAN EXPRESS Ask us about EASY PAY OPTIONS

WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which I give my consent for a credit check.

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If the (Provider's Name) must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by the (Provider's Name).**

Thank you for reading our Financial Alliance. Please let us know if you have any questions or concerns.

I have read the Financial Alliance. I understand, accept, and agree to this Financial Alliance.

Signature of Patient or Responsible Party

Date

Witness for (Provider's Name)

Date

MEDICAL HEALTH HISTORY PATIENT NAME: _____ DATE _____

CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

- Yes No Are you in good health?
Yes No Has there been a change in your health within the last year? Explain: _____
Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____
-

4. Yes No Are you being treated by a physician now? For what? _____

Name of your physician: _____ Date of last Medical Exam: _____

HAVE YOU EVER EXPERIENCED?

- | | |
|--|---------------------------------------|
| Yes No Chest Pains | Yes No Dizziness |
| Yes No Swollen Ankles | Yes No Ringing in ears |
| Yes No Shortness of breath | Yes No Frequent Headaches |
| Yes No Recent weight loss, fever, night sweats | Yes No Fainting spells |
| Yes No Persistent cough, coughing up blood | Yes No Blurred Vision |
| Yes No Bleeding problems, bruising easily | Yes No Seizures |
| Yes No Sinus Problems | Yes No Excessive thirst |
| Yes No Difficulty swallowing | Yes No Frequent urination |
| Yes No Constipation, blood in stools | Yes No Dry Mouth |
| Yes No Frequent vomiting, nausea | Yes No Jaundice |
| Yes No Difficulty urinating, blood in urine | Yes No Joint pain, stiffness |
| | Yes No Sleep apnea or chronic snoring |

DO YOU HAVE OR HAVE YOU HAD:

- | | |
|---|-----------------------------------|
| Yes No Heart disease | Yes No HIV positive or AIDS-ARC |
| Yes No Heart attack, heart defects | Yes No Tumors, Cancer |
| Yes No Heart murmur | Yes No Arthritis, rheumatism |
| Yes No Rheumatic fever | Yes No Eye disease |
| Yes No Stroke, hardening of arteries | Yes No Skin disease |
| Yes No High Blood Pressure | Yes No Anemia |
| Yes No TB, emphysema or other lung diseases | Yes No VD (syphilis or gonorrhea) |
| Yes No Hepatitis, A B C | Yes No Herpes |
| Yes No Stomach problems, ulcers | Yes No Kidney, bladder diseases |
| Yes No Diabetes | Yes No Thyroid, adrenal diseases |
| Yes No Family History of diabetes, heart problems, cancer | |

DO YOU HAVE OR HAVE YOU HAD:

- | | |
|---------------------------------|-------------------------------|
| Yes No Surgeries _____ | Yes No Radiation Treatments |
| Yes No Blood Transfusions _____ | Yes No Chemotherapy |
| Yes No Artificial Joint _____ | Yes No Prosthetic heart valve |
| Yes No Contact Lenses _____ | Yes No Pacemaker |
| Yes No Psychiatric Care _____ | Yes No Birth Control Pills |
| | Yes No Pregnant or nursing |

DO YOU TAKE OR HAVE TAKEN:

- Yes No Recreational drugs
Yes No Alcohol
Yes No Tobacco in any forms
Yes No Phen Phen diet Pills or any other diet pills
Yes No Fosamax

VITAMINS & MEDICATIONS: _____

ALLERGIES: to drugs, food, medications, metals, jewelry, acrylics; **list the following allergies:**

ALL PATIENTS:

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?
(For example: hip or knee replacements, stents)

DENTAL HEALTH HISTORY

Name of your Former Dentist: _____ How long since you were last seen? _____

How important is it for you to keep your teeth? 1 2 3 4 5 6 7 8 9 10 why? _____

On a scale of 1-10, 10 being the best, where would you rate your smile?

On a scale of 1-10, 10 being the best, where you rate your oral health?

Have you experienced any of the following problems:

Bleeding gums [Y] [N],

Bad Breath or sour taste in mouth [Y] [N]

Burning sensations in mouth [Y] [N]

Soreness in jaw [Y] [N],

Is it hard for you to open wide? [Y] [N]

Clicking or popping in jaw [Y] [N]

Have you or your parents suffer(ed) from Gum Disease? [Y] [N]

Did you ever wear braces? [Y] [N]

Oral Surgery of any kind? [Y] [N]

Sensitivity to Hot & Cold [Y] [N]

Snoring [Y] [N]

Food catching between teeth [Y] [N]

Clenching or Grinding of Teeth [Y] [N]

Pain/soreness around ears, eyes, face [Y] [N]

Stiff neck muscles [Y] [N]

Do you or your parents wear dentures/partials? [Y] [N]

Ever been injured in your mouth or head? [Y] [N]

Do you smoke or chew tobacco? [Y] [N]

Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

Is the brightness of your teeth important to you? [Y] [N]

If you could change anything about your smile which of the following would you want?

Whiter [Y] [N]

Close space or spaces [Y] [N]

Replace chipped teeth [Y] [N]

Replace missing teeth [Y] [N]

Replace old crowns [Y] [N]

Remove silver fillings [Y] [N]

Remove Stains/Spots on teeth [Y] [N]

Excess showing of Teeth [Y] [N]

Replace old plastic filling(s) [Y] [N]

Straighter [Y] [N]

Less Gum showing [Y] [N]

Reshape/resize my teeth [Y] [N]

Fill in this question for us please: Where do you see your overall oral health and/or your smile in the next 5 to 10 years?

Please circle the following which are important to you when making your dental health decision.

Convenience

Appearance

Relationship with Dental Team

Finances

Time

Quality of care

What insurance covers

Health

Detailed treatment explanations

Fear or Anxiety

Comfort

Technology

Other _____