Welcome! Thank you for selecting our dental team. We will always offer you the highest quality dental care available. In order to help us better serve you, please fill out these forms in their entirety as it is important for our files. Thank you for your cooperation.

Date ________________

Name ______________________________ Preferred Name ______________________________

Date of Birth ______________________________ Social Security # ______________________________

Circle one: Child Single Married Separated Widow Circle one: Female Male

Street Address______________________________ City, State, Zip ______________________________

Home Phone # ______________________________ Cellular Phone # ______________________________

Work Phone # ______________________________ Email ______________________________

Your Employer ______________________________ Your Occupation ______________________________

Responsible Party

Name______________________________ Relation to patient ______________________________

Date of Birth ______________________________ Social Security # ______________________________

Street Address ______________________________ City, State, Zip ______________________________

Home Phone # ______________________________ Cellular Phone # ______________________________

Email ______________________________

Dental Insurance

Primary Dental Insurance

Subscriber Name______________________________

Subscriber Employer______________________________

Subscriber DOB______________________________

Insurance Company______________________________

Insurance Address______________________________

____

Insurance Phone #______________________________

ID #______________________________

Group #______________________________

Secondary Dental Insurance

Subscriber Name______________________________

Subscriber Employer______________________________

Subscriber DOB______________________________

Insurance Company______________________________

Insurance Address______________________________

____

Insurance Phone #______________________________

ID #______________________________

Group #______________________________

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10

What would you like to change about your smile?

_____Color _____Bite _____Chipped Teeth _____Spaces _____Crowding _____Smile Makeover

_____Missing Teeth _____Whiter Teeth _____Replace Silver Fillings

Please mark any of the following conditions that apply to you

_____Discolored Teeth	_____Worn Teeth	_____Misshaped Teeth
_____Crooked Teeth	_____Spaces	_____Overbite
_____Flat Teeth	_____Sensitivity (hot, cold, sweet)	_____Pressure
_____Broken Teeth	_____Broken Fillings	_____Worn Teeth
_____Dry Mouth	_____Excessive Saliva	_____Grinding/Clenching
_____Headaches	_____Jaw Joint (TMJ) pain	_____Jaw Joint (TMJ) clicking/popping
_____Bad Bite	_____Speech Impediment	_____Mouth Breathing
_____Sore Muscles (neck, shoulders)	_____Difficulty Opening/Closing	_____Difficulty Chewing
_____Bleeding/Irritated Gums	_____Bad Breath	_____Loose/Shifting Teeth
_____Previous Perio/Gum Disease	_____Thumb Sucking	_____Nail-biting
_____Cheek/Lip Biting	_____Chewing Ice/Objects	_____Sleep Apnea
_____Snoring	_____Smoking	_____Chewing Tobacco
_____Alcohol Addiction	_____Drug Addiction	_____Difficulty Swallowing

Please share the following date:

-Your last cleaning__________-Your last oral cancer screening________-Your last Full mouth x-rays________

Name of Previous Dentist__________________________ Phone Number_____________________

Patient Name: ________________________________ **DOB:** __________ **Date:** ______________________
Address: ____________________________________ City: _________________ State: _____ Zip: _________
Home Number: _____________________________ Cell Number: ________________________________
Email: ____

Primary Dental Insurance: ____
Subscriber: ____ DOB: _________________
ID Number: ____ Group Number: _____________________

Secondary Dental Insurance: ____
Subscriber: ____ DOB: _________________
ID Number: ____ Group Number: _____________________

MEDICAL HISTORY

Please mark any of the following conditions that apply to you

___AIDS	___Dizziness	___HPV	___Scarlet Fever
___Alcohol Addiction	___Drug Addiction	___Jaundice	___Seizures
___Allergies (seasonal)	___Emphysema	___Jaw Pain	___Shortness of Breath
___Anemia	___Epilepsy	___Joint Pain	___Sinus Problems
___Anxiety	___Excessive Bleeding	___Kidney disease	___Sleep Apnea
___Angina (chest pain)	___Fainting	___Liver Disease	___Stomach Problems
___Arthritis	___Gastrointestinal Problems	___Low Blood Pressure	___Stroke
___Artificial Heart Valve	___Glaucoma	___Nervousness	___Thyroid Disease (hyper)
___Artificial Joints	___Heart Condition	___Nursing	___Thyroid Disease (hypo)
___Asthma	___Heart Lesions	___Pacemaker	___Tuberculosis
___Blood Disease	___Heart Murmur	___Psychiatric Illness	___Ulcers
___Bruise Easily	___Heart Surgery	___Pregnant	___Venereal Diseases
___Cancer	___Hepatitis A	___Radiation Therapy	___ Other ______________
___Chemotherapy	___Hepatitis B	___Respiratory Problems	____________________
___Cortisone Medication	___Hepatitis C	___Rheumatic Fever	____________________
___Depression	___High Blood Pressure	___Rheumatism	____________________
___Diabetes	___HIV Positive		

Are you allergic or have you reacted adversely to any of the following medications?

___Amoxicillin	___Aspirin	___Clindamycin	___Codeine	___Darvon
___Erythromycin	___Latex	___Local Anesthetics	___Nitrous Oxide	___Penicillin
___Percodan	___Sulfa	___Tetracycline	___Tylenol 3	___Valium

___Other____

ARE YOU UNDER A PHYSICIAN'S CARE? WHAT FOR? ____
____
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? ____
____
FAMILY PHYSICIAN ______________________________ PHONE NUMBER________________________

CONSENT: The undersigned herby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor 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 have read, understand and agree to the above terms and conditions. I certify that I have completed the above medical history thoroughly and have disclosed any and all of my medical conditions.

_______________________________________ **Date**_______________

Patient Signature

Financial Policy

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

Our fees are based on the quality materials we use and the time, effort, and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If you have insurance: (please initial all sections)

_____We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
_____As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to your, however, it is not a guarantee that your insurance will pay the amount estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
_____If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to make sure payment is expected. You will know if your insurance company has paid a claim, denied a claim, or needs additional information because you will receive an explanation of benefits or letter directly from them.
_____If your insurance company denies a claim, you will be responsible for paying the amount that was estimated they would pay at that time.
_____It is your responsibility to provide accurate insurance information no later than the day prior to your appointment. WE WILL NOT VERIFY BENEFITS THE DAY OF YOUR APPOINTMENT. If you are unable to provide us with accurate insurance information you will be responsible for paying our usual and customary fees the day of your appointment.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form authorizes us to submit your claims on your behalf to your insurance. This form authorizes us to instruct your insurance company to make payment directly to our office.

We ask that you pay the deductible and co-payment, which is an estimated amount, not covered by your insurance company. We accept cash, check, credit, or third party patient financing options.

We will cooperate fully with the regulations and requests of your insurance company that may assist in claims being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time the services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and /or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including call to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing call to us, to or from us, to or from any such number, without reimbursement from us.

_______________________________________ ______________

Patient Signature (Legal Guardian) Date

Cancellation Policy/Deposit Policy

Our practice is dedicated to quality care and exceptional service. We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you.

*Any appointments cancelled or rescheduled with 24 hours or less will incur a $25 charge for every 30 minutes reserved in our schedule. Most hygiene (cleaning) appointments are reserved for 1 hour.

*Any "no show" appointments (appointments where patient failed to notify our office they are unable to keep their reserved time) will result in not being able to schedule future appointments in advance. There will be a $25 charge for every 30 minutes reserved in our schedule.

*Any appointments cancelled or rescheduled must be done during our business hours (Mondays/Wednesdays 9am – 3pm and Tuesday/Thursdays 9am – 6pm). Any messages left with our answering service will be considered received the next business day that our office is opened.

*Any patient cancelling or rescheduling 2 consecutive times will no longer be able to schedule in advance.

*Appointments being reserved for 2 hours or longer may require a security deposit (deposit amount to be determined on case by case basis).

By signing below I certify that I have read and understand the above terms and conditions of this office. I am aware that any charges incurred because of cancelled, rescheduled, or "no show" appointments will be added to my account.

______________________________	______________________________	_______________
Patient Signature (Legal Guardian)	Printed Name	Date

Protecting Your Confidential Health Information
Is Important To Us

Notice of Privacy Practices
This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise
It is our desire to communicate to you that we are taking how the new Federal (HIPPA- Health Insurance Portability and Accountability Act) laws are written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now?
The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe that this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about the policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal laws regarding the confidentiality of your health information and in keeping with these laws; we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFOMRATION only for purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

To Provide Treatment
We will use your HEALTH INFORMATION within our offices to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

To Obtain Payment
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with the insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine procedures of certification, licensing or credentialing activities.

In Patient Reminders
Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. They may include postcards, folding postcards, letter, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we will believe we are specifically required or authorized by law or the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects or a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement purposes, including, under certain circumstances, if you are a victim of crime or in order to report a crime.

Family, Friends and Caregivers

We may disclose health information with those you tell us will be helping you with home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restriction on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communication that are sealed. We will make every effort to honor your reasonable request for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-ray and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for changes.
Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate or complete.

Documentation of Health Information

You have the right to ask us for a description of how and when your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your requests to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Authorization to Use or Disclose Health Information

Other than is stated above or when Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

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 acknowledgment.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

THIS FORM AUTORIZES US TO SUBMIT DENTAL CLAIMS ON YOUR BEHALF

I, ____________________________________, have received a copy of this office's Notice of Privacy Practices.

____

Patient Name (Legal Guardian)

____

Signature

____

Date

Authorization To Release Information

I, __________________________________, authorize the following person (s) to have access to information covered under the Privacy Practice regarding myself/

__________________________________	__________________________________
Name (printed)	Relationship
__________________________________	__________________________________
Name (printed)	Relationship
__________________________________	__________________________________
Name (printed)	Relationship

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 (INITIALS OF EMPLOYEE RECEIVING BLANK HIPPA ___________________)
_____Communications barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____Other (please specify

____

____