PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name _____
Last First MI (Preferred)

Birthdate _____ SS# _____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone _____ Wireless Phone _____ Wireless Carrier _____

Email _____ Employer _____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address _____

Address 2 _____

City _____ State _____ Zip _____

Home Phone _____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Comments:

Medical History for New Patient

Last Name: First Name: Birthdate:

Name of Medical Doctor: _____ Date of last health care exam: _____

Emergency Contact: _____ Phone _____ Relationship _____

Have you been hospitalized in the last 5 years? (Please circle) Y N

If yes, reason: _____

List all medications and/or dietary supplements that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems (Anemia, Blood Disorder)	☐	☐	Liver Disease or Hepatitis
☐	☐	Cancer or Tumor	☐	☐	Pregnancy
☐	☐	Epilepsy	☐	☐	Psychiatric Treatment
☐	☐	Diabetes	☐	☐	Sinus Trouble
☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Heart Trouble (Artificial Valve, Stent, or Pacemaker)	☐	☐	Ulcers
☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever
☐	☐	Joint Replacement (When placed?_____)	☐	☐	Emphysema or orther Respiratory/Lung Issue
☐	☐	Arthritis	☐	☐	HIV Infection/AIDS or ARC
☐	☐	Venereal Disease	☐	☐	Snoring

Have you ever been diagnosed with sleep apnea? Y N

If yes, do you wear a CPAP?

Have you ever been diagnosed with clenching or grinding? Y N Do you wear a biteguard? Y N

Tobacco use? If so, what kind and how much? _____

Do you use any mood altering drugs other than those previously listed? _____

Any other medical conditions or allergies not listed: _____

Do you have any issues that concern you with your teeth? _____

How often do your gums bleed? _____

Have you ever had any unusual reaction to dental injections? _____

Is there anything else that your dentist should know? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Date Patient Signature or Representative _____

Financial Agreement
Exceptional Dentistry

Last Name: First Name: Birthdate:

Date:

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. 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 responsbile for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

* Pre-payment is required for all prescribed/accepted dental treatment over $1000.00. Collecting in advance allows our office to reserve your time with the doctor. When you prepay for treatment, you are agreeing to take care of your dental needs. If circumstances change and you are refusing treatment and ask for a refund, there will be a 20% reduction of your pre-payment amount as well as the necessary cancellation fee. We have several payment methods we offer to our patients to assist them in taking care of their dental needs. If you use one of our finance companies and decide to change the terms of your account, you will be responsbile for all charges incurred. A $25.00 fee will be applied for any returned checks.

* As a courtesy, we will bill your insurance company for services that your policy will cover in order for you to meet your insurance maximums for the year. Once payment is received from the insurance company, you will receive a patient statement for the balance due. It is expected that your payment will be made within fifteen (15) days. If your payment is not received, it will be considered past due. There will be a service charge of 8% per annum on the unpaid balance on all accounts exceeding sixty (60) days, unless previously written financial arrangements have been made. If an account is turned over to a collection agency and/or attorney for collection, the account holder will be responsible for all attorney and/or collection fees. Any balance that is ninety (90) days past due is subject to being sent to collections.

* If an insurance company has not paid a claim after sixty (60) days of it being submitted, the office will require that the patient pay the account in full. This office will help prepare patient's insurance forms or assist in collecting from insurance companies and will credit any such collection to the patient's account. This dental office canot render services on the assumption that our charges will be paid by an insurance company.

* This office routinely provides our patients with an estimate of cost for the prescribed treatment. Since your insurance determines the benefits payable for services, the office cannot be held responsible for 100% accuracy on any estimate for treatment.

* I understand that many insurance companies downgrade coverage on non-metal restorations. I agree to the adjusted fees for the upgraded materials.

* As a condition of treatment by this office, financial arrangements must be made in advance, and financial responsibility (whether insurance remittance or patient portion) is determined before treatment. All emergency dental services, or any dental service performed without financial arrangements, must be paid in full at the time services are rendered.

*Rescheduling an appointment may be done up to 48 hours prior to your scheduled appointment without expense. If there is not a 24-hour cancellation notice for an appointment, you will be assessed a $25.00/hour fee. If an additional appointment is missed, you will be assessed a $50.00/hour fee. If a third appointment is missed, you will be assessed $100.00 and the practice reserves the right to dismiss any patient due to repeated scheduling or missed appointments.

* Accepted forms of payment include: cash, check, Visa, MasterCard, American Express and Discover. In addition, we offer CareCredit, a patient program offering a full range of no interest and extended payment plans.

We realize that temporary financial situations may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. We reserve the right to update this office policy at any time without notifications.

My signature verifies that I have read, understood, and accept the policies described above. My signature grants you or your assignee permission to telephone me at home, on my mobile phone, or at my work to discuss matters related to this form.

Patient or Representative Signature_____

Notice of Privacy Policies and Disclosure Authorization
Exceptional Dentistry

Last Name: First Name: Birthdate:

Date:

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.

Patient or Representative Signature_____

Disclosure Authorization

How may we contact you? (Please circle all that apply.) telephone mail email text

What telephone number may we call? (Please circle all that apply.) cell phone home phone work phone

NOTE: It will be your responsibility to be sure that we have the correct numbers on file.

Do we need to ask to speak to you? (Please circle one.) yes no

If you circled "no" to the question above, may we leave a message with whomever answers or on an answering machine/voicema

Is there any other individual/company that we may speak with in regards to your care and/or treatment needs? yes no

If yes, please list their names below.

_____

_____

_____

Photography Release
Exceptional Dentistry

Last Name: First Name: Birthdate:

Date:

Photography is used in dentistry as a record of care. Digital photography is used to assist the doctor with treatment planning. Digital photography taken during treatment is used by our laboratories for cosmetic purposes for the fabrication of crowns, veneers, bridges, dentures, and other prosthesis. Photographs are also used to help process insurance claims if necessary. These photographs are part of your permanent dental record.

My signature authorizes the right and permission to take and use digital photographs, videos, radiographs and/or study models of my smile, teeth, jaw and face. These photographs will be used as a record for my care and may be used for patient education, cosmetic dentistry and advertising (including but not limited to website, in office, and promotional materials). My signature authorizes that I understand that if my photographs, videos, radiographs, and/or study models are used in any way for publication or education, my name or other identifying information will be kept confidential. I do not expect compensation (financial or otherwise) for the use of any of the above mentioned items.

Please initial ONE of the following:
____I do consent to the use of photographs, videos, radiographs, and/or study models for use in patient education, cosmetic dentistry and advertising.

____ I do consent to the use of photographs, videos, radiographs, and/or study models for use in patient education, cosmetic dentistry and advertising EXCEPT full face or identifying views.

____I do not consent to the use of photographs, videos, radiographs, and/or study models for use in patient education, cosmetic dentistry and advertising.

____I do not consent to the use of digital photography and/or study models to be taken. I understand that I will be 100% responsible for treatment balance in full if a third party payor (i.e. dental insurance) requests additional information that the office can not provide due to my declination.

Patient or Representative Signature_____

General Consent for Treatment
Exceptional Dentistry

I voluntarily consent to dental examinations, treatments and/or procedures including x-rays, which are deemed necessary in the opinion of my dentist. I understand that above procedures may be performed by dentists, hygienist, and dental assistants.

I understand that no guarantees or warranties have been made to me concerning the results of the examinations, treatments or procedures. I understand that successful treatment often depends upon my cooperation in following my doctor's instructions. I agree to fully follow my doctor's instructions and to fully cooperate in my care, including keeping any necessarty additional appointments with my doctor, to enhance the possibility of successful treatment outcomes.

I understand that the doctors are available to patients once treatment has begun when the office is open and are available for after-hours consultation or care in the event of an emergency.

I authorize the doctors to take photographs and/or videos of my face, jaws and teeth. I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, and professional publications. I further understand that if the photographs and/or videos are used in any publication, or as part of a demonstrations, all reasonable attempts will be made to conceal my identity.

LOCAL ANESTHETIC CONSENT:
I understand that local anesthetic is used for many dental procedures. I understand that the use of local anesthetic is not required to provide the necessary dental care, however, the purpose of local anesthesia is to make it more comfortabe for me to receive the necessary dental care with less pain and/or anxiety. I accept and understand that local anesthesia will be administered by way of injection of an anesthetic agent into the oral mucosa of the mouth. I accept the alternatives to local anesthesia are: no local anesthesia, nitrous oxide, anxiolysis, oral or minimal sedation, IV or moderate sedation, and general anesthesia. The use of local anesthetics are been fully explained to me, including the risks involved. I have been fully informed that complications may include, but are not exclusive of: allergic reaction, loss of or disturbed sensation of the tongue and lip on the side of the injection that is often only temporary, but may become permanent. I understand that the position of the nerves under the tissue at the site of injection cannot be determined prior to the administration of the anesthetic agent. I consent to the use of local anesthetics as necessary for my care.

Patient or Representative Signature _____