THE DENTURE PLACE

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DATE: _____

PATIENT

Patient's Legal Name: _____ (Last) _____ (First) Preferred Name: _____ Male ☐ Female ☐

Birth date: ____/____/_____ Age: _____ SS# _____-_____-_____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone(____)_____-_____ Cell Phone(____)_____-_____

Appointments should be confirmed by
☐ Text Cell ☐ Call Cell ☐ Call Home

NEW PATIENTS

Previous/Current Dentist: _____ Last Visit Date: _____

How did you hear about us? _____

Other Family Members Seen by Us: _____ _____ _____

SPOUSE

Legal Name: _____ (Last) _____ (First) Birth date: ____/____/_____ SS#: _____-_____-_____

Cell Phone:(____)_____-_____ Employer: _____ Wk#(_____)_____-_____

DENTAL INSURANCE (PRIMARY)

Insured's Name: _____ Relation: _____ Insured's DOB: ____/____/_____

SS#: _____-_____-_____ Insured's Employer: _____

Insurancy Company: _____ ID: _____ Group# _____

Insurance Company Address: _____ City: _____

State: _____ Zip Code: _____ Phone # (_____)_____-_____

DENTAL INSURANCE (SECONDARY)

Insured's Name: _____ Relation: _____ Insured's DOB: ____/____/_____

SS#: _____-_____-_____ Insured's Employer: _____

Insurancy Company: _____ ID: _____ Group# _____

Insurance Company Address: _____ City: _____

State: _____ Zip Code: _____ Phone # (_____)_____-_____

CONTACT IN CASE OF EMERGENCY

Name: _____ Relation: _____ Phone # (____)_____-_____

The following persons are authorized to have access to billing, appointment, and treatment information (person responsible for account must be listed)

Name: _____ Relation _____ Name: _____ Relation _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

I understand I am responsible for payment of services at the time they are rendered. If this office participates with my insurance, I understand I am also responsible to pay any co-payment and deductible at the time service is rendered.

Patient Signature: _____ Date: _____

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MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain: _____
Are you taking any medications, pills or drugs?	O Yes O No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No	If yes, please explain: _____
Are you on a special diet?	O Yes O No	If yes, please explain: _____
Do you use tobacco?	O Yes O No	If yes, please explain: _____
Do you use controlled substances?	O Yes O No	If yes, please explain: _____

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex
☐ Sulfa Drugs ☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Recent Weight Loss	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Renal Dialysis	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatic Fever	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Leukemia	O Yes O No	Stomach/intestinal Disease	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsilitis	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Radiation Treatments	O Yes O No	Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? O Yes O No _____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

The law requires us to maintain your privacy, to give you this notice and to follow the terms of this notice. This notice describes how your health information may be used, disclosed and how you can access this information. Please review it carefully.

The law permits us to disclose your health information to those involved in your treatment. For example, a review of your file by a specialist whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, if you have insurance, we may send a report of your progress to your insurance company. We may also share information with our business associates, such as a billing service. We will have a written contract with each business associate that requires them to protect your privacy. All records containing health or personal information will be shredded if no longer needed and all such retained information will be kept secure.

We may use or disclose your information to contact you. For example, we may send you newsletter or other information. We will also call to confirm the time and day we have reserved for your dental care. If you are not home, we may leave this information on your answering machine or with the person who answers the phone. We may need to contact you from time to time. We will use whatever address and telephone number you prefer.

In an emergency, we may disclose your health information to your emergency contact or another person responsible for your care.

We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.
You may request in writing that we not use or disclose your health information as described above.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

You have the right to transfer copies of your health information to another practice. We will email your files for you. We will need a signed request for the transfer prior to sending any records.

I, _____ have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting THE DENTURE PLACE to release, use or disclose my protected health information.

Signature:_____ **Date:** _____

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FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that your payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications, and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS

Unless we receive notice of cancellation 48 hours in advance, you will be charged $50.00. Please help us service you better by keeping scheduled appointments.

INSURANCE

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.** If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance pays any portion.

Payment: Full payment is due at the time services are rendered. If Insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS** and **DEDUCTIBLES** are due at the time of service unless other arrangements have been made.

We accept VISA, MASTER CARD, AMERICAN EXPRESS, DISCOVER, CASH, CHECKS, CARECREDIT and more.

By signing this Financial Agreement, I have read, understand and agree the above.

Signature: _____ **Date:** _____

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Photo Release Form

I _____ hereby authorize "**The Denture Place**" to use my photos and videos (smile only), without my name for the purpose of educational and example representation ("Before and After shots") in publications which can include but will not be limited to: electronic publications, advertisement, promotions, website content, social media and other similar ways; without compensation or recognition given to me.

I have read and understand the above.

Signature:_____ **Date:** _____

Healthcare Agreement

Because dentistry is such a personalized service, a good rapport between dentist and patient is of vital importance. We believe in a relationship of mutual communication, trust, and understanding. Disruptive or inappropriate behavior such as verbal or physical abuse, destruction of office property, or accusations of false claims with malicious intent to damage reputation will lead to a patient's termination at our office. These behaviors impact our ability to provide proficient care for you and other patients.

By signing below, I acknowledge that I have read and understand the content of this agreement.

Signature:_____ **Date:** _____

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Appointment NO SHOW policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

Due to high patient demand and limited availability of appointments, we have a no-show fee that requires cancellation with at least 48-hour notice. We do not double book appointments; your appointment time is reserved exclusively for you.

Any appointment that is a no show will be subject to a $50.00 fee for the appointment that was booked. This fee will be billed directly to you, and not your insurance company.

By signing below, I acknowledge that I have read and understand this policy.

Signature: _____ **Date:** _____