Welcome To Our Practice

Patient Information Today's Date_____

Name_____

Last First Middle Initial Nickname

□Married □Single □Other □Male □Female Birth date_____ Age_____

Address_____

City_____ State_____ Zip Code_____

Phone(home)_____ Phone(cell)_____ Phone(work)_____

E-mail address_____ May we contact you at work? ◇ yes ◇no

Social Security #_____ Occupation_____

Employer Name_____

Employer Address_____

Emergency Contact/Spouse's Name_____ Birth date_____

Phone(home)_____ Phone(cell)_____ Phone(work)_____

Spouse's Employer_____

Employer Address_____

Whom may we thank for referring you to us?_____

Primary Dental Insurance

Subscriber Name_____ Social Security #_____ DOB_____

Employer Name and Address_____

Insurance Co. Name and Address_____

_____ Insurance Co. Phone_____

Group #_____ Policy/Subscriber ID#_____

Relationship to Patient_____

Secondary Dental Insurance

Subscriber Name_____ Social Security #_____ DOB_____

Employer Name and Address_____

Insurance Co. Name and Address_____

_____ Insurance Co. Phone_____

Group #_____ Policy/Subscriber ID#_____

Relationship to Patient_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance carriers and assign directly to Elma Family Dental all insurance benefits, if any, otherwise payable directly to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. The information on this page and the medical history are correct to the best of my knowledge.

Responsible Party_____ Relation to patient_____

Signature_____ Date_____

Dental History

Why have you come to the dentist today?_____

Are you currently in Pain? □yes □no Current Dental Health? □Good □Fair □Poor

Do you require antibiotics prior to dental treatment? □yes □no □unsure

Have you ever had a difficult or serious problem with previous dental work? □yes □no

Do you have a fear of the dentist? □none □mild □moderate □severe

Why did you leave your last dentist?_____

What did you like most about your last dentist?_____

Do you love your smile? □yes □no What would you like to change?_____

Do your gums ever bleed? □yes □no Have you ever had periodontal disease? □yes □no

How many times a week do you floss?_____ How many times a day do you brush?_____

Medical History

Have you ever had any of the following diseases or medical problems?

Please check all that apply.

Conditions:

- □ Abnormal bleeding
- □ Alcohol or Drug Abuse
- □ Aids/HIV
- □ Allergies
- □ Anemia
- □ Angina
- □ Asthma
- □ Blood transfusions
- □ Cancer/chemotherapy
- □ Diabetes
- □ Difficulty Breathing
- □ Emphysema
- □ Epilepsy
- □ Fever Blisters/Herpes
- □ Heart Attack: Date_____
- □ Heart Murmur/Defect
- □ Heart Surgery
- □ Hemophilia/bleeding
- □ Hepatitis: Type___
- □ Blood Pressure: high low

Medical History Continued

- ☐ Joint Replacement: Date_____
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Psychiatric Disease
- ☐ Radiation therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Trans Disease
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other_____

Allergies to:

- ☐ Aspirin
- ☐ Codeine
- ☐ Anesthetics
- ☐ Latex
- ☐ Metals/Jewelry/Nickel
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other_____

Miscellaneous:

Do you smoke? ☐yes ☐no

Do you chew? ☐yes ☐no

If Female:

Are you taking Birth Control Pills? ☐yes ☐no

Are you Pregnant? ☐yes ☐no

Current Medications and dosage:_____

_____

Physician Information:

Name of Current Physician_____ Phone_____

Name of Specialist Physician_____ Phone_____

OFFICE USE ONLY: Updates

1. Date_____ Comments_____ Signature_____

2. Date_____ Comments_____ Signature_____

Elma FAMILY DENTAL

Patient Policies

Notice of Privacy Practices: We keep a copy of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct that record. We will NOT disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about how your health information may be used and disclosed by contacting our patient coordinator.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of Patient or legally authorized individual — Date

_____ _____

Printed Name — Relationship to patient (if not self)

Cancellation, Late, or Missed appointment Policy: We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your oral health is something our office takes quite seriously. Because we care about you we realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the policies we ask you to adhere to.

We want to see you on time to have adequate time to do the necessary procedures. Arriving on time will permit all the treatment planned for the day. All appointments should be made before leaving the office, when possible, as our schedules fill quickly.

We expect you to keep all your appointments. With the exception of serious emergencies it is expected that you keep **all of** your appointments. **If you need to re-schedule an appointment we require a minimum 24 hours notice (one business day if cancelling on a weekend and 72 hours if cancelling a sedation or a 90 minute or greater appointment).** In such a case, please call our office and arrange for a make-up appointment with our Patient Coordinator.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $50.00 fee per hour. In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care, allow care on a space-available basis, or provide appointments on a pre-pay basis.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

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Financial Policies: We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget.

1) Dental Insurance: We welcome an open discussion of services and fees prior to treatment in order to avoid any kind of misunderstanding. Once insurance eligibility is determined, as a courtesy to you, **we will file for payment of your benefits for up to 30 days after treatment is completed. Beyond 30 days it will become your responsibility** to handle claims with your insurance representative. At this time your account will be due unless further arrangements have been made with our financial coordinator. _____ **Patient's Initials**

2) Co-Payment/Deductibles: We ask that your estimated **co-payment and deductible be paid at the time of your service**. We accept cash, checks, debit and credit cards. **Dental Insurance has limitations that we, as your dental provider, do not control; dental insurance is a contract between you and the insurance company. It is important to keep your account with our office up-to-date, regardless of the payment schedule of your insurance company.**
Ultimately, your bill is your responsibility. _____ **Patient's Initials**

3) Optional Payment Terms:

1. **Major Service – Two Payment Option:** We offer a two-payment option for crowns, bridges, root canals, and denture treatments. We ask that you pay one half of your treatment cost at the first appointment and the second half at the second appointment.
2. **Out of Office Financing:** By arrangement with Care Credit, we offer our patients, upon approval , an interest-free, low monthly payment plan option through these third parties with no down payment, no annual fee, and no pre-payment penalty. Please ask for a hassle-free application with an on-line decision in minutes.

4) Payment Policies: There is a $25.00 fee on all returned checks. **Accounts 30 days past due will accrue a 1.5% per month late payment charge on any amount over-due.**

By my signature below I acknowledge receipt of the appointment and financial policies.

_____ _____
Signature of Patient or legally authorized individual Date

_____ _____
Printed Name Relationship to patient (if not self)