Patient Information

Birth Date_____Today's Date_____SS#_____

□ Mr. □ Mrs. □ Ms. □ Dr. First Name_____M.I.____Last Name_____

Home Address_____
City State Zip Code

Cell Phone_____Home Phone_____Email Address _____

How do you prefer to be contacted? _____ May we use your email for promotions/giveaways? _____

Employer_____ Occupation_____

Employer Address_____

□ Married □ Single □ Widowed □ Separated □ Divorced Spouse's name_____

Emergency Contact_____ Phone Number _____

Primary Physician_____Last Physical Examination _____

Address_____Phone #_____

Primary Dentist_____Last Dental Treatment _____

Address_____Phone #_____

How did you hear about the practice? _____
□ Referring Doctor □ Internet □ Google □ Friend/Family □ Other

Referring Doctor: _____

Do you have any friends or family members that need dental implants or periodontal treatment?
_____

Dental Insurance Information:

Primary Dental Insurance
Subscriber's First Name:_____Last Name:_____DOB:_____
SS#_____Relationship to Patient: _____
Employer_____Work Phone:_____
Employer Address_____
Insurance Co._____Group #_____Phone#_____
Secondary Dental Insurance
Subscriber's First Name:_____Last Name:_____DOB:_____
SS#_____Relationship to Patient: _____
Employer_____Work Phone:_____
Employer Address_____
Insurance Co._____Group #_____Phone# _____

Dental Health History

Please select "yes" or "no" to indicate if you have had the following:

1. Do you have a specific problem or pain in your mouth?	NO	YES	11. Are you dissatisfied with the appearance of your teeth?	NO	YES
2. Have you ever had implant or periodontal (gum) treatment?	NO	YES	12. Do foods wedge between your teeth?	NO	YES
3. Did either your mother or father lose all their natural teeth?	NO	YES	13. Have you been under more nervous tension than average lately?	NO	YES
4. Have you had swollen areas or abscesses on your gums?	NO	YES	14. Do you smoke?	NO	YES
5. Do your gums bleed?	NO	YES	15. Are you aware of clenching, gritting, or grinding your teeth?	NO	YES
6. Have you noticed bad odors or tastes?	NO	YES	16. Do you have any teeth which are tender to biting or pressure?	NO	YES
7. Do you frequently breathe through your mouth?	NO	YES	17. Have you ever had a frightening experience with dentistry?	NO	YES
8. Do you have any teeth that are sensitive to heat, cold, or sweets?	NO	YES	18. Do you form calculus (tartar) or plaque rapidly on your teeth or been told you do?	NO	YES
9. Do you have any loose teeth?	NO	YES	19. Do you brush your teeth at least twice daily?	NO	YES
10. Have you ever worn braces?	NO	YES	20. Do you ever use dental floss, toothpicks, water sprays, or gum stimulators?	NO	YES

Medical History

Please list all medications, vitamins, herbs, supplements and over-the-counter medications you are currently taking_____

_____

Pharmacy name_____ Phone _____

Do you pre medicate before dental procedures?_____If yes, why? _____

Have you ever or are you currently taking:

Anticoagulants (blood thinners)	NO	YES	Reclast	NO	YES
Cortisone (steroids)	NO	YES	Zometa I.V.	NO	YES
Nitroglycerine	NO	YES	Fosamax, Actonel, Boniva	NO	YES
Radiation	NO	YES	Chemotherapy	NO	YES

Are you allergic to any medications or substances?

□ No known allergies □ Anesthetic □ Penicillin □ Acrylic □ Metal □ Latex □ Codeine or other narcotics

□ Valium or other tranquilizers □ Other _____

Have you ever had a major illness or operation?_____If so, when/ why?_____

Have you ever been hospitalized?_____If so, when/ why?_____

Please select “yes” or “no” to indicate if you have had the following:

Rheumatic fever or rheumatic heart disease	NO	YES	Blood transfusion	NO	YES
Congenital heart problems	NO	YES	Blood disorder	NO	YES
Artificial heart valve	NO	YES	Bleeding tendency	NO	YES
Cardiac pacemaker	NO	YES	HIV/ AIDS	NO	YES
High blood pressure	NO	YES	Sexually transmitted disease	NO	YES
Low blood pressure	NO	YES	Hepatitis	NO	YES
Chest pain/ Angina	NO	YES	Liver Disease	NO	YES
Irregular heart beat	NO	YES	Stroke	NO	YES
Heart attack	NO	YES	Epilepsy	NO	YES
Stent Date placed:	NO	YES	Thyroid trouble	NO	YES
Lung disease	NO	YES	Kidney trouble	NO	YES
Asthma	NO	YES	Eye disease/ glaucoma	NO	YES
Sinus problems	NO	YES	Cancer	NO	YES
Snoring/ Sleep apnea	NO	YES	Immune system problems	NO	YES
Respiratory problems	NO	YES	Joint replacement Date:	NO	YES
Tuberculosis	NO	YES	Alcoholism/ Drug addiction	NO	YES
Emphysema	NO	YES	Mental health problems	NO	YES
COPD	NO	YES	WOMEN:		
Osteoporosis	NO	YES	Are you nursing?	NO	YES
Diabetes Is it controlled? ____ Blood sugar level:	NO	YES	Are you pregnant or planning to be? Due Date: _____	NO	YES

Please list any other disease, condition or problem not listed above _____

_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtaining payment from third party payers (e.g. my insurance company) and the day-to-day healthcare operations of your practice.

I have also been informed of any and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use to disclosure that occurred prior to the date I revoke this consent is not affected.

CANCELLATION POLICY

Your appointment has been set aside just for you. Please notify our office 48 hours in advance, if you see the need to cancel or reschedule your appointment. If you have No-Showed for your appointment more than two times, you will be required to have a credit card on file for future appointments. Your credit card will be charged for any additional No-Shows for the amount of $30.00. This is a non-refundable fee.

FINANCIAL POLICY

Our practice accepts many dental insurance programs used by major employers in our area. Our goal is to maximize your insurance benefits and make any remaining balance affordable. Although our practice is “in-network” with many insurance plans, there are select plans within the insurance programs that our office is considered “out-of-network.” It is the patient’s responsibility to contact their insurance program prior to their appointment to confirm the practice is an “in-network” provider with their plan. We file insurance as a courtesy for our patients. Each insurance estimate is not a guarantee of payment made by your insurance company. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services rendered. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I understand I am responsible for all collection costs, attorney fees and court costs. We will discuss your estimated fees prior to the beginning of your recommend treatment. Fifty percent of the total due must be paid at the time of service. For your convenience, we accept cash, personal checks, and major credit cards (Visa, MasterCard, Discover, and American Express). Personal checks that are returned due to “insufficient funds” are subject to a $25.00 service fee. When more extensive dental care is necessary, financial arrangements can be made with our office.

AUTHORIZATION

I hereby authorize payment directly to Dr. Melanie Towe of the group insurance benefits otherwise payable to me. I understand that I am responsible for any portions of those services not covered by my insurance benefits. I hereby authorize this office to perform an oral examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize administration of such medications and perform such diagnostic, radiographic, photographic and therapeutic procedures as may be necessary for proper dental care. I give permission to use any close-up photos that they have taken of me for their office website or for continuing education presentations. I understand that care will be taken so my identity will not be revealed. The information on this page is correct and I grant the right to the dentist to release all information necessary to third party payers and/or other health professionals.

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor or any other member of his/ her staff responsible for any errors or omissions I have made in the completion of this form.

Patient Signature/Guardian Signature_____**Date**_____

Doctor Signature_____**Date**_____