## Who may we thank for referring you?

**Date**________________________

☐ Friends/Family Referring Patient ________________________________________ Relationship________________________
☐ Doctor
☐ Internet Source: ☐ YELP ☐ Google ☐ Zocdoc ☐ Other_____________________________
☐ Insurance
☐ Other Be Specific ___________________________________________________________________________________

## Patient Information

**Name**________________________________________________________ __________________________________________ __________
Last First Middle

**Date of Birth** _________/_________/_________ **SS#**_____________-__________-___________ **Gender** ☐ Male ☐ Female

**Marital Status** ___________________________ **E-Mail** _______________________________________@____________________________

**Address** ____________________________________________________________________________________________________________
Street Apt#

______________________________________________________________________________________________________________
City State Zip

**Phone Numbers** Home ____________________________ Cell_____________________________ Work _____________________________

**Emergency Contact** ____________________________________________________________ **Phone** ______________________________

## Responsible Party

**Name** _______________________________________________ **Date of Birth** _____/_____/_______ **SS#**_______-______-_________

**Address** ______________________________________________________________________________________________________________
Street Apt# City State/Zip

**Phone Numbers** Home ____________________________ Cell_____________________________ Work _____________________________

**Relationship** (Please check one) ☐ Parent ☐ Spouse ☐ Guardian ☐ Other

## Insurance Information

**Policy Holder** ________________________________ **Date of Birth** ______/_______/______ **SS# / ID #**_____________________

**Relationship to the Patient** (Please check one) ☐ Self ☐ Parent ☐ Spouse ☐ Guardian

**Policy Holder Address** ______________________________________________________________________________
Street Apt# City State/Zip

**Insurance Company** __________________________________________________ **Phone** _________________________________

**Employer Name** ___________________________________________________________ **Group #**__________________________

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Do you have any secondary insurance? ☐ Yes ☐No If Yes, Please complete the following

**Policy Holder** ______________________________________ **Date of Birth** ______/______/_______ **SS# / ID #**_________________

**Relationship to the Patient** (Please check one) ☐ Self ☐ Parent ☐ Spouse ☐Guardian

**Policy Holder Address** ______________________________________________________________________________
Street Apt# City State/Zip

**Insurance Company** ____________________________________________________ **Phone** ________________________________

**Employer Name** ___________________________________________________________ **Group #**__________________________

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## Patient Dental History

**Name of previous dentist**______________________________________________________ **Phone #**________________________

**What if your main purpose of today's visit?** ________________________________________________________________________

**Date of last visit to the dentist**_____________________________________ **Last cleaning**___________________________

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ | 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquid/foods? | ☐ | ☐ | 10. Do you bite your lips or cheeks frequently? | | |
| 3. Are your teeth sensitive to sweet liquid/foods? | ☐ | ☐ | 11. Have you ever had any difficult extractions | | |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ | in the past? | ☐ | ☐ |
| 5. Have you had any head, neck or jaw injuries? | ☐ | ☐ | 12. Have you ever had any prolonged bleeding | | |
| 6. Clicking in your jaw | ☐ | ☐ | following extractions? | ☐ | ☐ |
| 7. Pain in your jaw, ear, side of face | ☐ | ☐ | 13. Do you like your smile? | ☐ | ☐ |
| 8. Difficulty in opening, closing or chewing | ☐ | ☐ | 14. Have you thought about a smile makeover? | ☐ | ☐ |

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## MEDICAL HISTORY

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions (if you need more space, please indicate it on the comment section on the bottom of this page).

| | Yes | No | |
|---|---|---|---|
| Do you feel tired throughout the day? | ☐ | ☐ | If yes, please explain:___________________________________ |
| Have you been told you occasionally snore? | ☐ | ☐ | If yes, please explain:___________________________________ |
| Have you or a loved one been prescribed a CPAP Machine? | ☐ | ☐ | If yes, please explain:___________________________________ |
| Are you under a physician's care now? | ☐ | ☐ | If yes, please explain:___________________________________ |
| Have you ever been hospitalized or had a major operation? | ☐ | ☐ | If yes, please explain:___________________________________ |
| Have you ever had a serious head or neck injury? | ☐ | ☐ | If yes, please explain:___________________________________ |
| Are you taking any medications, pills or drugs? | ☐ | ☐ | If yes, please list : _____________________________________ _____________________________________________ |
| Do you take, or have you taken, Phen-Fen or Redux? | ☐ | ☐ | ______________________________________________ |
| Are you on a special diet? | ☐ | ☐ | ______________________________________________ |
| Do you use tobacco? | ☐ | ☐ | ***Women** : Are you ☐ Pregnant/Trying to get pregnant ☐ Nursing |
| Do you use controlled substances? | ☐ | ☐ | ☐ Taking oral contraceptives |

Are you allergic to any of the followings? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other ______________________________________________________________________

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

☐ Acid Reflux

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV positive | ☐ Cortisone Medicine | ☐ Hemophilia | ☐ Renal Dialysis |
| ☐ Alzheimer's Disease | ☐ Diabetes | ☐ Hepatitis A | ☐ Rheumatic Fever |
| ☐ Anaphylaxis | ☐ Drug Addiction | ☐ Hepatitis B or C | ☐ Rheumatism |
| ☐ Anemia | ☐ Easily Winded | ☐ Herpes | ☐ Scarlet Fever |
| ☐ Angina | ☐ Emphysema | ☐ High Blood Pressure | ☐ Shingles |
| ☐ Arthritis/Gout | ☐ Epilepsy or Seizures | ☐ Hives or Rash | ☐ Sickle Cell Disease |
| ☐ Artificial Heart Valve | ☐ Excessive Bleeding | ☐ Hypoglycemia | ☐ Sinus Trouble |
| ☐ Artificial Joint | ☐ Excessive Thirst | ☐ Irregular Heartbeat | ☐ Sleep Apnea/CPAP |
| ☐ Asthma | ☐ Fainting Spells/Dizziness | ☐ Kidney Problems | ☐ Spina Bifida |
| ☐ Blood Disease | ☐ Frequent Cough | ☐ Leukemia | ☐ Stomach/Intestinal Disease |
| ☐ Blood Transfusion | ☐ Frequent Diarrhea | ☐ Liver Disease | ☐ Stroke |
| ☐ Breathing Problem | ☐ Frequent Headaches | ☐ Low Blood Pressure | ☐ Swelling of Limbs |
| ☐ Bruise Easily | ☐ Genital Herpes | ☐ Lung Disease | ☐ Thyroid Disease |
| ☐ Cancer | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tonsillitis |
| ☐ Chemotherapy | ☐ Hay Fever | ☐ Pain in Jaw Joints | ☐ Tuberculosis |
| ☐ Chest Pains | ☐ Heart Attack/Failure | ☐ Parathyroid Disease | ☐ Tumors or Growths |
| ☐ Cold Sores/Fever Blisters | ☐ Heart Murmur | ☐ Psychiatric Care | ☐ Ulcers |
| ☐ Congenital Heart Disorder | ☐ Heart Pace Maker | ☐ Radiation Treatments | ☐ Venereal Disease |
| ☐ Convulsions | ☐ Heart Trouble/Disease | ☐ Recent Weight Loss | ☐ Yellow Jaundice |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: ________________________________________

**Comments:**

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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.

Patient's Name (Please print) ______________________________________________________ Date of Birth __________________________

Signature of Patient or Guardian ____________________________________________________ Date __________________________
(for patients under age of 18)

## Notice of Privacy Practice Acknowledgement & Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practice prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

______________________________________________
*Patients Name (please print)*

______________________________________________
*Signature of Patient or Guardian (if patient is under the age of 18)*

______________________________________________
*Relationship to Patient*

____________________
*Date*

*You are entitled to a copy of this Acknowledgement and Consent*

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

# Quince Orchard Dental Care Financial Policy

**Appointments:** A 48 hour notice is required to cancel appointments. Missed appointments and same day cancellations will be assessed a $50 fee per appointment. We understand that conflicts occur however, the more notice given, the better chance we have to appoint another patient in need of care. We ask that you respect our schedule as we do yours by seeing our patients in a timely manner.

**Self-Pay Patients:** Payment in full is required at the time services are rendered.

**Medicaid Patients:** It is your responsibility to confirm your eligibility. If at the time of service you are not eligible for benefits, you will be responsible for ALL charges. The office will allow **2 no show or same day cancellations.** After that we will provide emergency care for 30 days to allow you time to find a new dentist.

**Patients with Insurance:** Your insurance policy may or may not follow the American Academy of Pediatric Dentistry Guidelines. **It is your responsibility to know your own coverage.** If you do not want us to provide the recommended standard of care for your family, it is your responsibility to notify us. As a courtesy, we will file your claims. Any estimate given to you by the practice is purely an **estimate** and is due at the time of service. Insurance companies do not guarantee any payment until they receive the claim, review it, and approve it according to the specific policy terms. If there is a balance after the insurance payment is received, a bill will be generated and sent to you for immediate payment.

**Payment Methods:** **COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.** In an effort to provide you with flexible payment options, we have expanded our payment policy. We accept ☐Cash, ☐Personal Checks, ☐Visa, ☐MasterCard, ☐Discover, ☐American Express and ☐CareCredit. Please make your choice for any payment due today, sign below and return to the office prior to treatment. All items returned for non-sufficient funds are subject to a $30 fee. If none of the above apply, please see the office manager. Thank you.

**Balances:** Balances are to be paid within 30 days of receiving a statement. If balances are not paid in within 90 days, the account will be sent to a collection agency. You will be responsible for any costs incurred to collect including the collection agency fees, court costs, and attorney fees. If you have any questions or concerns regarding your bill, please contact the office.

If my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 18% accrued yearly, court costs, and attorney fees, as allowed by law.

Patient's First and Last Name: ________________________________________

Patient's Date of Birth: _________________

Signature of Patient and/or Guardian if patient is under the age of 18 (SEAL): ________________________________

Today's Date: _________________

***For Office Use Only:***

Witness Name: ____________________________________________________

Witness Signature: ________________________________________________