Center Of Dental Services

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Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient information

Name: _____ Soc. Sec. #:_____
Last Name First Name Middle initial

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Sex: ◯ M ◯ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by: _____ Occupation: _____

Business Address: _____

Business Email: _____ Business Phone:_____

Whom may we thank for referring you? _____

Notify in case of emergency: _____ Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email: _____

Primary Insurance

Person responsible for this account: _____ Relation to Patient:_____

Birth Date: _____ Soc.Sec.#: _____ Address (If different from patients): _____

Home Phone: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Email: _____

Business Phone: _____ Insurance Company: _____

Phone: _____ Insurance Email: _____

Contact #: _____ Group #: _____ Subscriber's #: _____

Name(s) of other dependentsunder this plain: _____

Additional Insurance

Is patient covered by additional insurance? ◯ Yes ◯ No

Subscriber's Name: _____ Relation to Patient: _____ Birth Date: _____

Address (If different from patients): _____ Soc.Sec.#: _____

City: _____ State: _____ Zip_____ Home Phone: _____

Cell Phone: _____ Email: _____

Subscriber Employed by: _____ Business Phone: _____

Insurance Company: _____ Phone: _____ Insurance Email: _____

Contact #: _____ Group #: _____ Subscriber's #: _____

Name(s) of other dependents under this plain: _____

Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist: _____ Address: _____ Phone: _____

Dentist's Email: _____

Date of last dental care: _____ Date of last X-rays: _____

Check Y for yes or N for no if you have or have not had the following:

Y N Bad breath	Y N Sensitivity to sweets	Y N Sensitivity to cold
Y N Food collection between teeth	Y N Bleeding gums	Y N Sensitivity when biting
Y N Periodontal treatment	Y N Grinding or clenching teeth	Y N Clicking or popping jaw
Y N Loose teeth or broken fillings	Y N Sensitivity to hot	Y N Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Medical History

Physician's name: _____ Address:_____ Phone: _____

Physician's Email: _____ Date of last visit: _____

Have you had any serious illnesses or operations? Y N If yes, describe: _____

Are you currently under physician care? Y N If yes, describe: _____

Have you ever had a blood transfusion? Y N If yes, give approximate date(s): _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check Y for yes or N for no if you have or have not had the following:

Y	N		Y	N		Y	N		Y	N	
◯	◯	AIDS/HIV Positive	◯	◯	Cough, persistent	◯	◯	High blood pressure	◯	◯	Shingles
◯	◯	Anaphylaxis	◯	◯	Cough up blood	◯	◯	Jaw pain	◯	◯	Shortness of breath
◯	◯	Anemia	◯	◯	Diabetes	◯	◯	Kidney disease or malfunction	◯	◯	Skin rash
◯	◯	Arthritis, Rheumatism	◯	◯	Epilepsy	◯	◯	Liver disease	◯	◯	Spina Bifida
◯	◯	Artificial heart valves	◯	◯	Fainting	◯	◯	Material allergies	◯	◯	Stroke
◯	◯	Artificial joints	◯	◯	Food allergies			(latex, wool, metal, chemicals)	◯	◯	Surgical implant
◯	◯	Asthma	◯	◯	Glaucoma	◯	◯	Mitral valve prolapse	◯	◯	Swelling of feet or ankles
◯	◯	Atopic (allergy prone)	◯	◯	Headaches	◯	◯	Nervous problems	◯	◯	Thyroid disease or
◯	◯	Back problems	◯	◯	Heart murmur	◯	◯	Pacemaker/Heart surgery			malfunction
◯	◯	Blood disease	◯	◯	Heart problems	◯	◯	Psychiatric care	◯	◯	Tobacco habit
◯	◯	Cancer	Describe:_____			◯	◯	Rapid weight gain or loss	◯	◯	Tonsillitis
◯	◯	Chemical dependency	◯	◯	Hemophilia/	◯	◯	Radiation treatment	◯	◯	Tuberculosis
◯	◯	Chemotherapy			Abnormal bleeding	◯	◯	Respiratory disease	◯	◯	Ulcer/Colitis
◯	◯	Circulatory problems	◯	◯	Herpes	◯	◯	Rheumatic fever	◯	◯	Venereal disease
◯	◯	Cortisone treatments	◯	◯	Hepatitis	◯	◯	Scarlet fever	◯	◯	Bisphophonates

List medications you are currently taking, if any:

_____

List drug allergies, if any:

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____

Payment is due in full at time of treatment unless prior arrangements have been approved

MEDICAL INSURANCE INFORMATION

Primary MEDICAL Insurance Company: _____

Group Number: _____ ID#: _____

Address: _____

Name of insured: _____

Insured SS#: _____ Insured Date of birth: _____

Insured Employer: _____ Phone Number: _____

Address: _____

Patient's Relationship to insured: _____

Secondary MEDICAL Insurance Company: _____

Group Number: _____ ID#: _____

Address: _____

Name of insured: _____

Insured SS#: _____ Insured Date of birth: _____

Insured Employer: _____

Address: _____ ID#: _____

Patient's Relationship to insured: _____

BROKEN APPOINTMENT POLICY

When a dental appointment is made in our office, a specific time is reserved for the patient to see the dentist. The appointment allows the dentist to meet the patient's needs and also schedule other equally important patients.

Broken appointments result in a loss of valuable time that could be spent with patients in need of treatment and they are very costly to our office. For this reason, if a patient fails to keep an office visit he or she will be charged a fee for a broken appointment.

In addition, because we are not in the position to determine if an excuse is valid or not, no **exceptions** will be made to this policy.

It is the patient's ultimate responsibility to keep their scheduled appointment. If an appointment does need to be cancelled or rescheduled for any reason, please notify our office with 24 hours in advance of the appointed time, and no broken appointment fee will be charged.

Thank you for your anticipated cooperation.

Signed: _____ Date: _____
(Patient or guardian)

PATIENT LIABILITY STATEMENT

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR CHARGES INCURRED FOR SERVICES RENDERED BY: ***CENTER OF DENTAL SERVIVES*** IF ANY OF THE FOLLOWING APPLY:

1. My health plan requires prior authorization before receiving services and I have not obtained such an authorization or I received services in excess of such authorization.

AND / OR

2. My Dental plan coverage has lapsed or expired at the time I receive services.

AND / OR

3. I have chosen **NOT** to use my Dental plan coverage.

I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CO-PAYMENTS AND CO-INSURANCE SUMS UNDER MY DENTAL PLANS.

I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR THE BALANCE OF THE BILL THAT IS NOT PAYABLE BY MY INSURANCE PLAN OR SECONDARY PLAN.

FURTHERMORE, I AGREE, THAT IF LEGAL ACTION BECOMES NECESSARY DUE TO MY FAILURE TO PAY MY RESPONSIBILITES, THE COST OF THAT ACTION TOGETHER WITH INTEREST, ALLOWED BY LAW, WILL ALSO BE PAYABLE BY ME.

PRINT PATIENT NAME:_____ GUARANTOR NAME IF NOT PATIENT:_____

SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES NOTICE and DESIGNATION OF DISCLOSURE
Patient Receipt Acknowledgment

I. Acknowledgment of Privacy Practice Notice

I, _____ , acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my Individually Identifiable health Information, or request additional confidential treatment of communications between the Practice and myself or others.

_____ _____

Signature of Patient / Parent / Guardian Date

_____ _____

Witness Relationship

II. I wish to be contacted in the following manner (check all that apply)

- ◯ Home telephone: _____
- ◯ OK to leave a message with detailed information
- ◯ Leave message with call back number only
- ◯ Work telephone: _____
- ◯ OK to leave message with detailed information
- ◯ Leave message with call back number only
- ◯ Written communication
- ◯ OK to mail to my home address
- ◯ OK to mail to my work / office
- ◯ OK to fax to this number: _____
- ◯ Other _____

III. Designation of certain Relatives, Close Friend and Other Caregivers

I agree that Center Of Dental Services may disclose certain health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my healthcare, In that case, Center Of Dental Services will disclose only information that is directly relevant to the person's Involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of Center Of Dental Services making the limited disclosures described above. I understand that I am not required to list anyone and that I may change this list at any time in writing. I also understand this only valid for one year from the date signed.

Print Name: _____ Last 4 digits of SSN: _____

Print Name: _____ Last 4 digits of SSN: _____

Print Name: _____ Last 4 digits of SSN: _____

_____ _____

Signature of Patient / Parent / Guardian Date