# INSURANCE AND FINANCIAL POLICY

## DENTAL INSURANCE ASSIGNMENT AGREEMENT

*We accept and file insurance as a courtesy to our patients. We ask that if you would like for our office to submit your dental insurance for you, that you* ***read*** *and* ***agree*** *to the following:*

* *Provide* ***all*** *of the information requested on this form, including a copy of your driver's license and insurance card.*
* *We ask that you pay your* ***estimated*** *portion at the time services are rendered. We do our best with the information given to figure your out of pocket expense, but there may be deductibles, amounts above the maximum plan benefit that will be your responsibility.*
* *We are not a collection agency for your insurance company. We are not responsible for claims that are "lost" or "never received" by the insurance company or for reimbursements associated with the claims. We always file* ***all*** *of the appropriate information available and necessary to process a claim. At that point we may charge processing and handling fees to get more involved.*
* *If after 30-45 days from the date of service there remains a balance, we will exercise your guarantee of payment to clear the balance, irregardless of your insurance company's actions.*

***I understand and accept these terms for dental insurance assignment:***

***X*** _____ ***X*** _____

***Patient signature or legal guardian*** ***Date*** ***Witness***

## ACCOUNT GUARANTEE

*Visa/MC/Discover/CareCredit Acct#*_____ *Exp Date*_____

*Cardholder Name*_____

*Authorized signature*_____

## INSURANCE INFORMATION

*Patient Name*_____ *DOB*_____ *SS#*_____

*Insured Name*_____ *DOB*_____ *SS#*_____

*Employer*_____ *Insurance Company*_____

*Group Number*_____ *Insurance Company Phone#*_____

*Claims mailing address*_____

*Relationship to Insured: Self Spouse Dependent Other:* _____
*explain*

# PATIENT INFORMATION—HEALTH HISTORY

## PERSONAL INFORMATION

Patient Name_____
First Middle Last Preferred (Nickname)

Date of Birth_____ DL#_____ SS#_____

Spouse/Parent_____ patient here also? ___yes ___no

Home address_____
Street city state zip

Patient's/Parent's Employer_____ Occupation_____

Employer's address_____
Street /PO Box city state zip

Home phone_____ Cell phone_____ Work phone_____

Email address_____(soon to be used for appointment confirmation/reminder)

## MEDICAL INFORMATION

Physician's name_____ Office phone_____

Pharmacy name_____ phone_____

Emergency Contact_____ phone_____

List Medications currently taking:_____

_____

_____

Drug Allergies: _____

Allergic to Latex? yes no Problems with local anesthetics? yes no

Reactions to any metals? (e.g. nickel, mercury, etc.) yes no Nursing? Yes no

Are you pregnant? yes no ____trimester _____ oral contraceptives? yes no
1,2,3 due date

# DENTAL HEALTH QUESTIONAIRE

PATIENT:_____AGE_____DATE:_____

REASON FOR VISIT:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

LAST DENTAL VISIT_____WHAT WAS DONE THEN?_____

PREVIOUS DENTIST (name & location)_____

LAST COMPLETE SERIES OF XRAYS TAKEN WHEN, WHERE_____

HOW OFTEN DO YOU BRUSH?_____ HOW OFTEN DO YOU FLOSS?_____

IS YOUR DRINKING WATER FILTERED?_____FLUORIDATED?_____

**(CHECK ALL THAT APPLY)**

_____teeth cleaned in last year
_____teeth sensitive to hot or cold
_____discomfort chewing
_____sores, lumps in or near mouth
_____difficulty opening or closing
_____frequent headaches
_____bite plate, nightguard, NTI
_____biting lips or cheeks
_____catching food between teeth
_____gum treatment in past
_____prolonged bleeding in past
_____bad reaction to novocaine
_____choke/gag easily
_____wear dentures or partial denture
_____concerned about wisdom teeth

_____x-rays in last year
_____teeth sensitive to sweet or sour
_____bleeding gums
_____head, neck, or jaw injury in past
_____joint pain, popping jaw
_____clenching or grinding
_____sports mouthguard
_____teeth feel loose
_____sore gums
_____difficult extractions in past
_____hard to get numb in past
_____difficulty leaning back
_____nervous about dental treatment
_____have had dental implants
_____unsatisfied with smile

_____must have nitrous gas for treatment (fee of $90/hr, 1 hr minimum)
_____must be or would like to be sedated for dental treatment (inquire for fees)

_____interest in cosmetic dentistry
_____interest in Invisalign
_____interest in natural colored fillings
_____interest in replacing missing teeth
_____interest in lifelike dentures

_____interest in ortho/braces
_____interest in Lumineers
_____interest in whitening
_____interest in implants
_____interest in anti-snoring

**Patient signature**_____**Date**_____

**HEALTH QUESTIONAIRE**

PATIENT:_____ AGE_____ DATE_____

**(CHECK ALL THAT APPLY)**

_____in good health
_____physical in last 12 months
_____surgery in last 12 months
_____health change in last 12 months
_____tobacco use, type
_____chemical dependency

_____presently under medical treatment
_____currently taking prescription medication
_____taking non-prescription substances
_____recent weight loss
_____alcohol use, frequency_____
_____psychological treatment

NOTES:

_____abnormal bleeding
_____heart murmur or defect
_____rheumatic fever
_____heart attack year:_____
_____pacemaker
_____joint replacement year:_____

_____bruise easily
_____mitral valve prolapse
_____scarlet fever
_____chest pain, angina
_____heart surgery
_____stent year:_____

NOTES:

_____abnormal blood pressure
_____Stroke year:_____
_____frequently tired
_____lung, breathing problems
_____sinus trouble
_____tuberculosis
_____hives or skin rash
_____sexually transmitted disease
_____hepatitis, liver disease
_____stomach troubles, ulcers
_____head, neck injury
_____diabetes, type_____
_____cancer, type_____
_____chemotherapy, dates_____
_____cortisone treatment, dates_____
_____arthritis, rheumatism
_____glaucoma
_____auto-immune disease
_____eating disorders

_____swollen ankles, feet, hands
_____fainting or dizzy spells
_____easily winded
_____asthma or hay fever
_____chronic cough
_____cough that produces blood
_____allergies
_____HIV/Aids infection
_____thyroid; hypo hyper
_____kidney disease
_____seizures, convulsions
_____hypoglycemia
_____tumors
_____radiation, areas_____
_____back problems
_____cold sores, fever blisters
_____wears contacts
_____immune suppressed
_____other:_____

**Patient signature**_____ **Date**_____

# INFORMATION REGARDING SOME OF OUR POLICIES

## DENTAL TREATMENT ON CHILDREN

**We love children!!!!** We encourage moms and/or dads to bring their children to their hygiene appointments no matter what their age. It gives us a chance to interact with them and begin developing a trusting relationship. We like to begin "gentle nudging" at 16-24 mos. and have had several children let us polish their teeth at 18 mos. old. Most will consent between 24-30 mos, but no invasive procedures (those requiring an injection) are done until a certain stage of mental and emotional development, usually around 9 yrs of age. Unpleasant procedures before this stage have the potential of creating a phobia that may prevent the child from even getting a cleaning as an adult.

It is for this reason that we will only do preventative, non-invasive procedures on younger children. We refer to a child specialist for the more unpleasant procedures and keep the preventative, more pleasant procedures totally separate. **There has never been a child who was afraid to come to our office!** It allows for the child to develop excellent hygiene habits at an early age -- and these children seldom need invasive procedures later on.

Please initial_____

## APPOINTMENT SCHEDULING

The schedule is the single most important aspect of the office in that if it is out of control, nothing is in control and there would be chaos (have you ever been to an emergency room?). It is for this reason that we design the schedule with specific blocks of time for certain procedures. Even though we carefully plan the day, urgencies and emergencies present themselves at most inconvenient times. Occasionally this will require that we reschedule procedures of a non-emergency nature to accommodate, but more frequently it would mean that our schedule continues, but with unavoidable delays. We ask that you be understanding of the situation and realize that someone else is less fortunate than you at the moment. Rest comfortably knowing that if you or one of your loved ones were in the same predicament, that we would do our very best to address those needs as well.

Please initial_____

## CANCELLING AN APPOINTMENT

When you make an appointment, the time is blocked for you, reserving the facilities, the necessary personnel (hygienist, hygiene assistant, sterlization technician, dental assistant), and necessary doctor time and incurs a fee of one half of the services that would have been rendered if cancelled without a minimum of two working days. This gives us a reasonable chance of filling that time that had been reserved for you. The alternative method is to come at 8, 10, 1, or 3 and we will try to work you in around scheduled patients, first come first served -- no guarantees. Privilege comes with a price.

Please iniitial_____

## PAYMENT FOR SERVICES

Payment for service is expected at the time of service unless other payment arrangements have been made. If you have elected to assign benefits to our office, then your estimated portion would be expected unless other payment arrangements have been made. We accept persoal checks with proper identification and MC, VISA, Discover or cash. Please do not assume that we will "just send you a bill"; there are options available to you if you will take the time to discuss them with our financial consultants.

I, (print name)_____agree to be ultimately responsible for the payment of dental services provided for me or my dependents.

X_____ X_____

Signature of patient or legal guardian Date Witness

## AUTHORIZATION AND RELEASE

By signing this form you will consent to our use and disclosure of you or your dependant's protected health information to carry out treatment, payment activities, and healthcare operations. You may revoke this consent at any time by giving us written notice of your revocation by certified mail. Additionally, you are attesting that all of the information that you have provided is accurate to the best of your knowledge, realizing that incorrect medical information can be dangerous to your health or the health of your dependent.

X_____ X_____

Signature of patient or legal guardian Date Witness

## CONSENT FOR TREATMENT

By signing this section you will be granting general consent for the doctor hygienist, and/or dental assistant to peform those dental and hygiene procedures that they are legally qualified to perform that are necessary for the gathering of specific medical/dental information and for routine preventative care for you and your dependents. (Dental procedures that are more invasive would require an additional signed consent, e.g. fillings, crowns, extractions, root canals, etc.)

X_____ X_____

Signature of patient or legal guardian Date Witness