

Welcome!

Thank you for your visit today! We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask, we will be glad to help. We look forward to working with you!

PATIENT INFORMATION

Name _____ Date _____
HomePhone _____ Cell Phone _____ Social Security# _____ Birthdate _____
Address _____
City _____ State _____ Zip Code _____
Email Address _____ How do you prefer to be contacted?(circle one) Phone _____ Email _____
Sex (circle one) Male Female Single Married Widowed Divorced Seperated
Occupation _____ Employed by _____
Business address _____ Work Phone _____
Whom may we thank for referring you? _____
Who is responsible for this account? _____
Whom may we notify in case of an emergency? _____ Phone _____

PRIMARY DENTAL INSURANCE INFORMATION

Name _____ Birthdate _____ Social Security# _____
Relation to Patient _____ Home Phone _____ Work Phone _____
Address (If different from patient's) _____
Employed By _____ Employer's Address _____
Insurance Company (Plan Name) _____ Phone Number _____
Insurance Company Address _____ Group# _____ Policy # _____

SECONDARY DENTAL INSURANCE INFORMATION

Is patient covered by additional insurance? Yes No
Name _____ Birthdate _____ Social Security# _____
Relation to Patient _____ Home Phone _____ Work Phone _____
Address (If different from patient's) _____
Employed by _____ Employer's Address _____
Insurance Company (Plan Name) _____ Phone Number _____
Insurance Company Address _____ Group # _____ Policy # _____

- I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.
- I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

• **Signature** _____ **Date** _____

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

HEALTH HISTORY

Although dentists primarily treat the area in and around your mouth, it is important for us to know all facts relative to your present and past health. Certain medications and health conditions could have an important interrelationship with the treatment that you will be receiving. The following information is strictly confidential.

Patient's Name: _____ Date of Birth _____

How do you prefer to be addressed? _____

1. Date of last Physical Examination _____ Physician's Name: _____

2. Have you been hospitalized during the past two years? YES/NO If yes, please explain: _____

3. Have you been under the care of a physician in the past two years? YES/NO If yes, please explain _____

4. Are you allergic to or made sick by penicillin, aspirin, codeine, local anesthetics, latex, or any other medication? YES/NO If yes, please explain _____

5. Have you ever had excessive bleeding requiring special treatment? YES/NO If yes, please explain _____

6. Circle any of the following that you have had or have at present:

- | | | |
|---------------------------|--------------------------|--------------------------------------|
| Heart Failure | Kidney Disorders | HIV Positive, ARC, AIDS |
| Heart Disease/Attack | Ulcers | Infectious Disease (Date) _____ |
| Angina Pectoris | Use of Tobacco Products | Drug Addiction |
| High Blood Pressure | Alcoholism | Psychiatric Treatment |
| Emphysema | Glaucoma | Venereal Disease |
| *Mitral Valve Prolapse | Tuberculosis (TB) | Steroid Therapy |
| *Heart Murmur | Asthma | Hepatitis (Type: _____) |
| *Rheumatic Fever | Sinus Problems | Liver Disease |
| *Congenital Heart Lesions | Hay Fever | Sickle Cell Disease |
| Heart Pacemaker | Allergies or Hives | Blood Transfusion (Date) _____ |
| *Artificial Heart Valve | Diabetes | Bleeding Disorder |
| Heart Surgery | Radiation Treatment | Bruise Easily |
| Anemia | Arthritis | *Any Type of Transplant |
| Stroke | Fainting or Dizzy Spells | *Any Type of Implant |
| Epilepsy or Seizures | Thyroid Disease | *Artificial Hip, Knee or other Joint |
| Cancer (Type: _____) | Chemotherapy | |

*Antibiotic premedication may be required prior to your appointment

7. Please list or furnish a list of ALL medications and dosages you are currently taking (including over the counter medications, vitamins, or herbal remedies) _____

Comments: _____

8. **WOMEN:** Are you pregnant? YES/NO
Are you nursing? YES/NO
Are you taking birth control pills or hormone replacement therapy? YES/NO

DENTAL HISTORY

Answers to the following questions are for our records only and will be considered confidential:

1. Date of last Dental Examination: _____

2. Date of last Dental X-rays: _____ Type: BWX_____ FMX _____ Panograph_____

Circle

YES NO 3. Are you having pain or discomfort at this time? _____

YES NO 4. Do you feel very nervous about having dental treatment? _____

YES NO 5. Have you ever had a bad experience in the dental office? _____

YES NO 6. Is there anything that you dislike about your smile? _____

YES NO 7. Have you ever had instructions in oral hygiene? How often do you floss? _____ Brush? _____

YES NO 8. Are there now any growths or sores in or around your mouth? _____

YES NO 9. Do you have any trouble chewing? _____

YES NO 10. Does food catch between your teeth? _____

YES NO 11. Do you have pain in or near your ears? _____

YES NO 12. Do you habitually clench or grind your teeth during the day or night? _____

YES NO 13. Have you ever been diagnosed with or received treatment for TMJ pain/dysfunction _____

YES NO 14. Have you ever been told that you have gum disease? _____

YES NO 15. Do you now have bleeding gums or any other gum condition? _____

YES NO 16. Is there anything related to your medical or dental history that you have not indicated? _____

17. Purpose of this dental visit? _____

To the best of my knowledge, all of the information on both sides of this form is true and correct. If there is any change in my health, or my medications, I will inform the doctor prior to any treatment.. I understand that my health history information will be used as necessary for diagnosis or treatment by the doctor(s) of Dental Arts, P.C. I understand that antibiotics may reduce the effectiveness of birth control pills.

Signature: _____

Date: _____

I have reviewed my medical history and the above (including any changes) is accurate: Date: _____ Initials: _____
Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____
Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____
Clinician: _____ Date: _____ Blood Pressure: _____ Clinician: _____ Date: _____ Blood Pressure: _____
Clinician: _____ Date: _____ Blood Pressure: _____ Clinician: _____ Date: _____ Blood Pressure: _____
Clinician: _____ Date: _____ Blood Pressure: _____ Clinician: _____ Date: _____ Blood Pressure: _____
Clinician: _____ Date: _____ Blood Pressure: _____ Clinician: _____ Date: _____ Blood Pressure: _____

Dental Arts, P.C.
3421 E. Garfield, Laramie, WY 82070

To our Valued Patients,

Today in our world of rising prices we are trying to keep our fee increase to a minimum by implementing clear and exact payment policies. This will help to reduce our overhead, thus passing the savings along to our patients. Our payment options and policies include:

FINANCIAL MENU

A) Prepay Courtesy (for fees over \$500)

A prepayment courtesy of **5% (10% if Senior Citizen, over 65)** will be subtracted from the total patient obligation (not from any portion due from insurance company) if the patient obligation is **paid in full by check or cash** at the **first treatment visit**.

B) Care Credit Plan

With fast approval over the phone or online from Care Credit, your payments can be much lower than those available through our office. Their short credit application takes only minutes to complete. Care Credit requires no down payment, 0% if payment made in full within the interest free period and offers several payment options.

C) Three Payments (for fees over \$1000)

Total patient obligation may be divided as follows: **50%** due at the **first treatment visit**, with the remaining **balance split into two equal payments**, due **30 and 60 days** after the first treatment visit. For any fees under \$1000, the full amount is due at the *initiation* of any treatment. Balance payments will be *written* at the initiation of treatment, post-dated for 30 and 60 days and will be held for deposit until those dates occur.

D) Pay as You Go. You may choose to pay your obligation for each visit, *at* the visit.

FORMS of PAYMENT and BALANCE DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following (including any combination thereof): **Cash, Visa, Mastercard, Money Order, Personal Check or Care Credit (see above).**

INSURANCE

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. Our goal is to assist you in obtaining your insurance benefits as expeditiously as possible, therefore, we ask you to help us achieve that goal by providing us with your most current insurance information and we will submit your claims within 24 hours of treatment. We will initially ask you *only for your estimated co-payment*. Please understand that this is *only an estimate*, and is based upon the information available to us.

The range of benefits depends solely on what you employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means **80% of the fee arbitrarily determined by the insurance company** and not the actual fee charged by our office. Our office does not participate in any preferred provider dental plans. However, as a courtesy to our patients we will file claims to those plans for you.

The **financial obligation for dental treatment is between you and our office.** The insurance company is **responsible to you, and not to our office.** We will assist you in any way that we can. Once your carrier has paid the claim, any difference will be due upon receipt of our statement. If for *any reason*, we have **not received** your **insurance carrier's** payment **45 days** after the claim, the **remaining balance** will be due and **payable by you**, and subject to a 18% APR.

Patient signature _____ Date _____

ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, was notified of the Privacy Policy.

Please Print Name

Signature

Date

For Office Use Only

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)
