

# Health History Form



American Dental Association  
www.ada.org

E-mail: \_\_\_\_\_ Today's Date: \_\_\_\_\_

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: <small>Last</small> _____ <small>First</small> _____ <small>Middle</small> _____	Home Phone: <i>Include area code</i> ( ) ( )	Business/Cell Phone: <i>Include area code</i> ( ) ( )
Address: <small>Mailing address</small> _____	City: _____	State: _____ Zip: _____
Occupation: _____	Height: _____	Weight: _____ Date of birth: _____ Sex: M F
SS# or Patient ID: _____	Emergency Contact: _____	Relationship: _____ Home Phone: ( ) ( ) Cell Phone: ( ) ( ) <small>Include area codes</small>

If you are completing this form for another person, what is your relationship to that person?

Your Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Do you have any of the following diseases or problems:** **(Check DK if you Don't Know the answer to the question)** **Yes No DK**

Active Tuberculosis .....

Persistent cough greater than a 3 week duration .....

Cough that produces blood .....

Been exposed to anyone with tuberculosis .....

**If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.**

## Dental Information For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

## Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ( ) ( )				If yes, what was the illness or problem?			
Address/City/State/Zip: _____				Are you taking or have you recently taken any prescription or over the counter medicine(s)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

# Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p><b>(Check DK if you Don't Know the answer to the question)</b></p> <p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p><b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began: _____</p>	<p>Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____</p> <p><b>WOMEN ONLY</b> Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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<p><b>Allergies -</b> Are you allergic to or have you had a reaction to: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK To all <b>yes</b> responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Metals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Latex (rubber) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Iodine _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Hay fever/seasonal _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Animals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Food _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

	Yes	No	DK	Yes	No	DK
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date: _____						
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/ Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____						
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____						
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of infection: _____						
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches/ migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?  Yes  No  DK

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about?  Yes  No  DK  
Please explain: \_\_\_\_\_

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# HIPAA

## NOTICE OF PRIVACY PRACTICES SUMMARY

This describes how your health data may be used and shared and how you can get access to this data.

- I. How we may use your health data:
  - a) Treatment-We may use or share your health data to give you medical treatment or other types of services.
  - b) Payment-We may use or share your health data to bill you or a third party for payment for services provided to you.
  - c) Healthcare Operations-We may use and share your health data for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc.
- II. Disclosures we do not have to give you a chance to agree or object:
  - a) To you
  - b) As required by federal, state, local law enforcement.
  - c) If child abuse or neglect is suspected.
  - d) Public health risks for the purpose of preventing and controlling of disease.
  - e) Lawsuits and disputes in response to a court or administrative order.
  - f) Law enforcement to help officials respond to criminal activities.
  - g) Coroners, medical examiners and funeral directors
  - h) Organ or tissue donation facilities if you are an organ donor.
  - i) To avert a threat to individual or public health and/or safety.
- III. Disclosures where we must give you a chance to agree or object:
  - a) Patient directories-You can decide what health data you want to be listed in the patient directories.
  - b) Persons involved in your care or payment of your care-we may share your health data with a family member or other person that YOU name as being involved with you healthcare.
- IV. Your rights for your health data:
  - a) Right to inspect your health record and to receive a copy of your health record upon request.
  - b) Right to amend information in your health record that may be incomplete or inaccurate.
  - c) Right to know to whom we have disclosed your health information.
  - d) Right to limit who receives your health information (in accordance with state laws)
  - e) Right to a copy of the complete Notice of Privacy Practices.

Notice of Privacy Practices Receipt

I acknowledge that I have received the Notice of Privacy Practices Summary of Eatontown Dental Care.

Signature of Patient or Representative \_\_\_\_\_

Print Name and Date of Birth \_\_\_\_\_

Date \_\_\_\_\_

## EATONTOWN DENTAL CARE APPOINTMENT POLICY

We value you as our patient and need your cooperation with keeping appointments so that we can provide all of our patients the care needed. Missing or late cancelling an appointment means we are unable to offer this appointment time to another patient who may desperately need care.

Our policy requires:

- Appointment Confirmation: Our office will call/text to confirm your appointment as a courtesy. Please call to confirm your appointment no less than one business day before the scheduled appointment by 5:00pm **OR** reply to the text confirmation that is sent.

Initials: \_\_\_\_\_

- Timely Cancellations: If you need to cancel or reschedule your appointment, please give us at least 24 hours' notice. Any cancellation or rescheduling made less than 24 hours will result in a cancellation fee of \$50.

Initials: \_\_\_\_\_

- On Time Arrivals: If you are more than 10 minutes late to your appointment, please call the office to advise us you are running late.

Initials: \_\_\_\_\_

Your help in keeping your appointment enables us to provide better and more timely care for all of our patients.

Patient/Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT RESPONSIBILITY FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

We will assist you with your dental insurance. We will submit claims for treatment performed. We will appeal denials, if applicable. We will request pre-authorizations, if applicable, for planned major procedures, in accordance with your insurance company policy. We will ask for your assistance with you insurance company, if applicable. Insurance quotes and pre-authorizations are an estimate only. Although we preauthorize major procedures with your insurance company, this is not a guarantee of payment. Coverage may be different if your deductible has not been met, annual maximum has been met, your insurance company denies our request for authorization or your insurance applies an alternate benefit.

**Co-pays:** I understand that I am responsible to pay all co-payments, at the time of service. I understand that I am responsible to pay last payment of restorative dental work at the final insert appointment, if applicable.

**Deductible:** If my insurance company determines that I have not met my deductible, I understand that I will be responsible to pay the deductible at the time of service, if applicable.

I acknowledge that I assume full responsibility for services rendered if my insurance carrier downgrades or does not cover my claim for treatment performed. I understand the terms of this agreement and accept financial responsibility with or without the use of insurance coverage.

Signature of patient or representative: \_\_\_\_\_ Date: \_\_\_\_\_

### Whom may we thank for referring you?

- Friend/Family member (name/relationship): \_\_\_\_\_
- Website: \_\_\_\_\_
- Internet search (circle one)- Google, Yahoo, Yelp, Facebook, Zocdoc, Healthgrades....
- Newspaper/print: \_\_\_\_\_
- Insurance company: \_\_\_\_\_
- Patient- (name): \_\_\_\_\_
- Co-worker-(name): \_\_\_\_\_
- Other: \_\_\_\_\_