Welcome to Our Practice

How did you hear about our office? _____

Name as it appears on drivers license:_____

Birth Date:_____/_____/_____ Social Security Number:_____-_____-_____ Sex: **M/F**

Address:_____

City:_____ State:_____ Zip Code:_____

Marital Status: Minor/Single/Married/Divorced/Widowed Email:_____

Home Phone:_____ Cell Phone:_____

Person Responsible for the account:_____Phone:_____

Emergency Contact Name:_____ **PH:**_____

Do you like your smile? Y/N

What would you like to change about your smile?

_____

Dental History: (answer to the best of your knowledge)

Bad breath	Y / N	Bleeding gum	Y / N	Foreign objects	Y / N
Chew on one side of mouth	Y / N	Cigarette, pipe or cigar smoking	Y / N	Lip or cheek biting	Y / N
Fingernail biting	Y / N	Food collection between teeth	Y / N	Orthodontic treatment	Y / N
Gum swollen or tender	Y / N	Jaw pain or tiredness	Y / N	Sensitivity to heat or cold	Y / N
Mouth breathing	Y / N	Mouth pain while brushing	Y / N	Burning sensation of tongue	Y / N
Periodontal treatment	Y / N	Sensitivity to sweet	Y / N	Grinding teeth	Y / N
Sensitivity when biting	Y / N	Sores or growths in your mouth	Y / N	Loose teeth or broken fillings	Y / N
Clicking or popping of jaw	Y / N	Frequent blist	Y / N	Pain around ears	Y / N
Dry mouth	Y / N	Do you floss at least once a day?	Y / N	Do you brush at least once a day?	Y / N

Health History: (answer to the best of your knowledge)

AIDS/HIV	Y / N	Mitral valve prolapse	Y / N	Emphysema	Y / N
Back problems	Y / N	Hepatitis A,B, C,	Y / N	Radiation treatment	Y / N
Headaches	Y / N	Chemical dependency	Y / N	Mental Disabilities	Y / N
Shortness of breath	Y / N	Herpes	Y / N	Steroid treatment	Y / N
Artificial joints/pins	Y / N	Swelling of feet and ankles	Y / N	Kidney disease	Y / N
Epilepsy/Seizures	Y / N	Blood disease	Y / N	Sinus problems	Y / N
Heart murmur	Y / N	Circulatory problems	Y / N	Tuberculosis	Y / N
Respiratory disease	Y / N	High blood pressure	Y / N	Diabetes	Y / N
Dramatic weight loss	Y / N	Nervous problems	Y / N	Liver disease	Y / N
Jaw pain	Y / N	Anemia	Y / N	Swollen neck glands	Y / N
Pacemaker	Y / N	Congenital heart lesions	Y / N	Skin rash	Y / N
Bleeding abnormality	Y / N	Jaundice	Y / N	Persistent/bloody cough	Y / N
Thyroid problems	Y / N	Chemotherapy	Y / N	Low blood pressure	Y / N
Stroke	Y / N	Ulcers	Y / N	Fainting or dizziness	Y / N
Psychiatric care	Y / N	Tonsillitis	Y / N	Artificial heart valve	Y / N
Heart problems	Y / N	Scarlet fever	Y / N	Venereal Disease	Y / N
Heart defects	Y / N	Autoimmune disease	Y / N	Ever taken Phen Phen	Y / N
Osteoporosis	Y / N				

Please describe any other health condition that you might have not included in the list above:

_____

_____

Are you currently taking any medication? (If yes then please list all medications you are taking):

_____

_____

Do you have any drug allergies? Y / N

_____

_____

Photography: Photographs are used on a regular basis for diagnostic, teaching and some cases for marketing reasons. All privacy etiquettes are followed. If you have any questions or concerns, please talk to one of our team members.

For Females Only:

- Are you taking birth control medication or are you on any other birth control system? **YES / NO**
- Are you breastfeeding? **YES / NO**

If you are pregnant or if there is a chance you could be pregnant, please notify the office staff immediately (**this applies to this appointment or any other future appointment)**

FINANCIAL, TREATMENT POLICY AND CONSENT

Please read and ask questions if you do not understand, then sign this policy:

After we verify insurance benefits we cannot guarantee that the information we receive is a guarantee of payment. Insurance companies state that coverage is only an **estimation** of benefits. You are ultimately responsible for knowing what your plan covers or does not cover and if there are waiting periods for to be performed. Any amounts not covered by your plan, except for contractual fee discounts, are your financial responsibility.

Balances Due Per the Explanation of Benefits (EOB): After insurance has processed the insurance claim, balances are due immediately upon receipt of a bill from this office. If I disagree with the amounts due per my EOB, it is not only responsibility to contact the insurance company immediately for resolution of the problem, but also to pay any balances due to this office at that time pending the resolution of the problem with the insurance company.

New Insurance Information as well as **Changes in Insurance** must be provided to this office prior to any appointment. Failure to provide correct and current insurance information may result in the entire bill being my own responsibility.

Insurance Requests for Additional Information must be responded to immediately. This includes documentation of college student's full time status, proof of continued enrollment in an insurance plan (usually following open enrollment), and dual insurance verification. Failure to provide this information to the insurance company in a timely manner may result in the entire bill being my own responsibility.

Statements are sent on a monthly basis and as needed. I will remit payment by mail immediately upon receipt of a bill. I agree to contact the office immediately if I have any questions regarding a bill I may receive. Bills are not sent out only for informational purposes, but to notify me of payment expected from this office.

Balances That Exceed 90 Days I understand that if I allow my account balance to exceed 90 days, I may receive a **Final Notice** letter. Failure to pay my account or arrange a payment plan within 10 days may result in my account being turned over to a collection agency. If this happens, a **Collection Fee** of 29% of the balance sent to the collection agency will be added to my account balance, and I will have to find another dentist within 30 days. I understand that the collection agency will report unpaid balances to the major credit bureaus, and this will remain on my credit report for 7 years. Before I can be seen in this office again, I understand that all fees must be paid. When we send to collection agency we will add 29% of the balance to the fee being collected.

Changes in Address or **Telephone Numbers** should be provided immediately as soon as a change occurs. I understand that if the office cannot contact me via telephone or mail about my outstanding balance, my account will be turned over to a collection agency for further collection activity.

Returned Checks will incur a $30 fee (or whatever the law allows). The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card. I understand that the office will no longer accept personal checks for payment once a check is returned. And no further treatment will be rendered until allowed amount is paid.

Changes made by insurance company on your benefits This office is not responsible for changes made by your insurance company on the procedure code done and billed by our office. (Example would be: a certain procedure is done in this office, and changed by your insurance company to a different procedure benefit or several procedures bundled into one benefit)

We do not use silver (amalgam) filling in this office if your insurance company changes any procedure done in this office to a silver filling code, you are responsible for the difference in price.

We take necessary radiographs for diagnosis reasons and to comply with the standard of care and the needs of the doctors for diagnosis. This office is not responsible if insurance denies a radiograph claim for any reason.

Cosmetic procedures are done in this office on a regular basis at the consent of patients. You are ultimately responsible for the balance if your insurance company determine the procedure unnecessary for cosmetic reason.

Assignment of benefits we will file your insurance as a courtesy to you on the understanding benefits are a contract between you and your insurance, and in the event your insurance denies coverage or payment, you are ultimately responsible for the remaining balance. By signing this agreement you (or any of your dependents) assign directly to this dental office and dentists all insurance benefits, otherwise payable to you as service rendered. You are also giving us authorization to release all information necessary to secure the payment of benefits. Your signature will be also used for all insurance submission.

Please ask one of our team members if you have any other questions about our treatment and financial policies. The office financial policy is subject to change, and fair changes will apply to all existing and new patients without notice or prejudice.

Please sign below to acknowledge understanding of the entire financial policy:

_____ _____

(Patient's Signature/Parent or Guardian's Signature if a minor) **(Date)**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996("HIPPA"), 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 acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 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 healthcare options. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Contact Consent

May we contact you by email and text to remind and confirm future appointments?
Yes/No

May we contact you by email with treatment estimates or anything pertaining to your dental records?
Yes/No

_____ _____

(Patient Signature/Guardian) **Date**

Artistic Dentistry Appointment Policy

Our practice is dedicated to quality care and exceptional service. Our dentists and team spend extensive amounts of time preparing for your visit**. Broken and missed appointments create scheduling problems** for our team; can be costly to our office, and unfair to other patients who need appointments. Recently we have seen an increase in cancellations and broken appointments without proper notice. **Due to this increase**, **our office has implemented a new policy.**

- **A $50 fee will be charged to your account if 48 hour advance notice is not given.**
- **For 3 consecutive broken appointments a $50 deposit will be required to schedule your next appointment** which will be applied towards your treatment.
- **Any appointment 90 minutes or longer requires prepayment to hold your appointment.**
- If you do not arrive within **15 minutes** of your appointment, we will have to **reschedule and you will be charged a cancellation fee of $50**.
- **Above deposits will be forfeited** if you fail to keep the appointment or cancel without a 48 hour notice.

We have invested in technology to confirm your appointment via email/text/phone. We can be reached 24 hours a day by all three methods.

We do understand that occasionally there are unforeseeable events that require your immediate attention and we will do everything possible to accommodate those rare instances.

Thank you for your consideration in this matter.

Patient Signature_____ **Date**_____

PAYMENT OPTIONS

If you would like to keep a credit/debit card on file for the convenience of processing your payments for dental treatment please list your information below. All major credit cards are accepted including Care Credit.

Circle one: Visa / MC / Discover / Amex / Care Credit

Card#: _____ Exp: _____ CVC: _____

Billing address: _____ Zip Code: _____

I, _____ hereby authorize Artistic Dentistry to process payments from time to time as the dental office deems necessary to settle/pay my account in full.

_____ _____

Patients Signature **Date**