New Patient Information

Patient Name _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security _____ Birth Date: _____

Phone (Home) _____ (Work) _____ (Cell) _____ (Other) _____

Address: _____ Email: _____

City State Zip Code

Referral Information

How did you hear about us or whom may we thank for referring you to our practice? _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Street City State Zip Code

Student Information

If you are a student, please list: **School Name:** _____ **Enrollment Status:** _____

Your school contact information: _____

If you are 18 or older, or signing consent for a minor, you are the responsible party.

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell) _____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Although dental personnel primarily treat the area in around your mouth, your mouth is part of your entire body, health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Current Physician _____ City _____ State _____ Phone _____
- Preferred Pharmacy: _____ Location _____ Phone _____
- Are you now under the care of a physician? ☐ Yes ☐ No Doctor's Name _____ If yes, please explain: _____
- Do you have any/pins/plates/artificial joints? ☐ Yes ☐ No Surgeon's Name _____ If yes, please explain: _____
- Do you use tobacco in any form? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications, pills, or drugs? ☐ Yes ☐ No Blood Thinner? ☐ Yes ☐ No
  If yes, please explain: _____
- Ladies: Are you pregnant or nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No
- Have you ever taken Boniva, Reclast, Fosamax, Aredia or Zometa? ☐ Yes ☐ No

PLEASE MARK ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH HISTORY

☐ Pre-Med - Amoxicillin
☐ Allergy-Codeine
☐ Allergy-Penicillin
☐ Anemia
☐ Artificial Joints
☐ Bruise Easily
☐ Cortisone Medicine
☐ Epilepsy/Seizures
☐ Frequent Cough
☐ Head Injury
☐ Hemophilia
☐ Hypoglycemia
☐ Mitral Valve Prolapse
☐ Psychiatric Care
☐ Sinus/Hay Fever
☐ Tuberculosis
☐ Pre-Med - Clindamycin

☐ Allergy - Erythromycin
☐ Allergy - Sulfa
☐ Angina/Chest Pain
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Excessive Bleeding
☐ Frequent Headaches
☐ Heart Murmur
☐ Hepatitis A
☐ Irregular Heart Beat
☐ Pain in Jaw Joints
☐ Radiation/Chemo Tx
☐ Stomach Problems
☐ Tumors
☐ Pre-Med Other

☐ Allergy - Keflex
☐ Allergy-Anesthetics
☐ Art Heart Valve
☐ Blood Disease
☐ Cold Sore/Fever Blister
☐ Drug Addiction
☐ Excessive Thirst
☐ Glaucoma
☐ Heart Pacemaker
☐ Hepatitis B or C
☐ Kidney Prob/Disease
☐ Pins/Plates
☐ Respiratory Problems
☐ Stroke
☐ Ulcers
☐ Allergy - Aspirin

☐ Allergy - Latex
☐ Alzheimer's Disease
☐ Arthritis/Gout
☐ Blood Transfusion
☐ Cong Heart Disorder
☐ Emphysema/COPD
☐ Fainting/Dizziness
☐ H/L Blood Pressure
☐ Heart Trouble /Disease
☐ HIV/AIDS
☐ Liver Disease
☐ Pregnancy
☐ Rheumatic Fever
☐ Taking BCP

Please list any other drugs or medications that you are allergic to that is not listed above:

_____

- Previous Dentist: _____City: _____Phone: _____
- Approximate date of last dental cleaning and full mouth x-rays _____
- How often to you brush your teeth? _____ How often do you floss? _____
- Are you have dental discomfort currently? ☐ Yes ☐ No
- Does Food catch between your teeth? ☐ Yes ☐ No
- Do your gums bleed when brushing your teeth? ☐ Yes ☐ No
- Do you have a problem with bad breath? ☐ Yes ☐ No
- Do you clench your teeth during the day or night? ☐ Yes ☐ No
- Do you have pain in or near your ear? ☐ Yes ☐ No
- Do you have popping/clicking in your jaws? ☐ Yes ☐ No
- Do you have any growths or mouth sores? ☐ Yes ☐ No
- Do you have any current or future interest in orthodontics (braces)? ☐ Yes ☐ No
- Have you ever seen a periodontist, had gum treatments or surgery? If yes, please list name of Doctor:

_____

- Have you or your family ever seen an oral surgeon/endodontist (root canal) another specialist? If yes, list name of Doctor:

_____

- Have you had difficult extractions in the past? If yes, please explain:

_____

I certify that I have read the information above. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____Date_____

CONSENT FOR CARE & TREATMENT

I, the undersigned, do herby agree and give my consent for UNIVERSITY GENERAL DENTISTRY to furnish dental care to

(PRINT NAME) _____ considered necessary & proper in diagnosing or treating his/her dental condition.

Patient/Guardian/Responsible Party **(SIGN NAME)** _____ **Date** _____

BENEFIT ASSIGMENT/RELEASE OF INFORMATION

I hereby assign all dental and/or medical benefits to include major medical benefits to which I am entitled, including private insurance and third-party payors to UNIVERISTY GENERAL DENTISTRY. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian/Responsible Party **(SIGN NAME** _____**)** **Date** _____

FINANCIAL POLICY STATEMENT

We bill your insurance solely as a courtesy to you. Even though we may try to give estimates of your insurance benefits, this is done solely as an ESTIMATE and we cannot be held responsible for what your insurance ultimately chooses to pay or not to pay. Estimated coverage information is provided as a courtesy to you, but is not intended to release you from your responsibility for your account balance. It is up to you to be aware of your insurance benefits. Any disputes between you and your insurance company are your responsibility to resolve. You are responsible for your bill at time of service fee less than $150.00. We accept cash checks and some bank cards. Some financial arrangements may be made for fees more than $150.00 but all copays and deductibles are due at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due from you in full and any further filings at this point become your responsibility. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. There is a $2.00 per month rebilling fee on accounts over 90 days old.

If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same to UNIVERSITY GENERAL DENTISTRY, as long as you have any balance remaining in this office.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court cost, collection agency fees, rebilling fees, late fees and attorney fees.

Patient/Guardian/Responsible Party **(SIGN NAME)** _____ **Date** _____

Office Representative **(SIGN NAME)** _____ **Date** _____

BROKEN/CANCELLED APPOINTMENT POLICY

We make every effort to be on time for our patients and ask that you extend the same courtesy to us and other patients. We strive to have timely appointments available to patient that need to be seen quickly. Therefore, we need to be notified with in 24 hours if you are unable to keep an appointment, so that we may offer that time to someone who has an immediate need. Certainly, emergencies such as illness to occur and we do not wish to penalize patients for unavoidable situations; however, we do want to discourage repeated abuse of our scheduling process, which is ultimately unfair to those who are diligent about keeping their appointments.

If you are more than ten minutes late for an appointment and there is not enough time remaining in the schedule to complete your planned treatment before our next patient is due, your appointment may need to be rescheduled for a mutually convenient day and time.

IN ANY CASE, A CANCELLATION FEE OF $50.00 MAY APPLY.

I have read the above information. **I UNDERSTAND MY RESPONSIBILTY TO COMPLY WITH THIS POLICY & THE CHARGES THAT MAY APPLY IF FAIL TO DO SO.**

Patient/Guardian/Responsible Party **(SIGN NAME)** _____ **Date** _____

UNIVERSITY GENERAL DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT _____

_____

I, (PRINT NAME) _____, have received a copy of this office's Notice of Privacy Practices and understand that I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

PRINT NAME _____ SIGN NAME _____ DATE _____

IF CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

PRINT NAME _____ SIGN NAME _____ DATE _____

You are entitled to a copy of this consent if you so desire. Refusal to sign this form will prohibit us from completing certain tasks on your behalf such as filing insurance, confirming your appointment, calling in prescriptions, arranging appointments for you at other offices and mailing re-care cards among other things.

Alternative People Communication Authorization Form

Patient Name: _____ SSN _____

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner as possible. There are certain occasions when family members, friends or others might be involved in your case as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we can discuss your care and share your protected health information.
Please list below any other people with whom you authorize our office to discuss aspects related to your care.

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

Do we have permission to leave messages on voice mail or answering machines?

YES _____ NO _____

Patient/Responsible Signature: _____ Date: _____