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| **Patient Information** |
| Date: |       |  |  |  |  |  |
| Patient: |       |       |       |       |       |  |
|  | First | MI | Last | Preferred | Title |  |
|  | [ ] Male [ ] Female | [ ] Child\*[ ] Student\*\* | [ ] Single[ ] Married[ ] Divorced[ ] Widowed |
| \*If Child, provide parent/guardian name(s) below: | \*\*If Student, please complete: [ ] Full-time [ ] Part-Time |  |
|  |       |  |  |       |  |
|  | Parent/Guardian Name(s) |  |  | School/Location |  |
| Patient Date of Birth: |       | Patient SSN: |       |  |
| Address: |       |  |  |
|  | Address Line 1 |  |  |  |
|  |       | Cell: |       |  |
|  | Address Line 2 | Work: |       |  |
|  |       |       |       | Other: |       |  |
|  | City | ST | ZIP Code |  |  |  |
| E-Mail: |       |  |  |  |
| Referral? | [ ] Yes [ ]  No | Referred by: |       |  |
|  |  |  | Internet Search[ ]  Website[ ]  Mailer[ ]  Insurance[ ]  |  |
|  |  |  | Social Media [ ]  Other[ ]  |  |

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| **emergency Information** |
| In case of emergency, please provide information for the nearest relative or designated contact person: |
|  |       |       |  |       |  |
|  | Name | Relationship |  | Mobile |  |

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| **employment Information** |
| Employer: |       | Occupation: |       |  |
| Phone #: |       | Email: |  |  |
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| **insurance Information** |
| Subscriber: |       |       |       |       |       |  |
|  | First | MI | Last | Preferred | Title |  |
| Subscriber Date of Birth: |       | Subscriber SSN/ID#: |       |  |
| Subscriber Employer: |       |  |
| Patient Relationship to Subscriber: | [ ] Self [ ] Spouse[ ] Child[ ] Other      |  |
| **Primary Insurance Carrier:** |       |  |
| Group/Policy No.: |       | ID No.: |       |  |
| Address: |       | Tel: |       |  |
|  |       | Toll-free: |       |  |
|  |       |       |       | Fax: |       |  |
|  | City | ST | ZIP Code |  |  |  |

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| **Previous Dentist Information** |
| Dentist: |       | Telephone: |       |  |
| Clinic/Facility: |       |  |
|  |       |       |       |  |
|  | City | ST |  |  |
| Reason for changing: |       |  |
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| **dental history** |
| Oral Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor |
| Date of Last Dental Visit: |       | Treatment Type:  |       |  |
|  |  |  |  |  |
| Would you like to have an advanced oral cancer screening? [ ] Y[ ] N  |
|  *\*Note: Some insurance plans do not cover this service; please check your plan documents for details.* |
| [ ] Y[ ] N | Are you currently having dental discomfort? If yes, explain: |       |  |
| [ ] Y[ ] N | Are you able to chew and speak well? If NO, please explain: |       |  |
| [ ] Y[ ] N | Do you like the shape of your teeth?: If NO, please explain |       |  |
| [ ] Y[ ] N | Are your teeth chipped? |  |
| [ ] Y[ ] N | Are your teeth protruding? |  |
| [ ] Y[ ] N | Are your teeth crowded? |  |  |
| [ ] Y[ ] N | Are your teeth worn? |  |
| [ ] Y[ ] N | Are your teeth spaced apart? |  |
| [ ] Y[ ] N | Do you like the color of your teeth? |  |
|  | Would you like to change the appearance of your teethby: |  |
| [ ] Y[ ] N | Straightening them? |  |
| [ ] Y[ ] N | Reshaping them? |  |
| [ ] Y[ ] N | Whitening them? |  |
| [ ] Y[ ] N | Do you clench or grind your teeth? If so, Do you wear a nightguard or splint?[ ] Y[ ] N |  |
| [ ] Y[ ] N | Did your last dentist review the goals of your long-term health? If yes, please explain below: |  |
|  |       |  |
| What do you like the least about your smile? |  |
|  |       |  |
| What do you like the most about your smile? |  |
|  |       |  |
| The most important concerns about your dental treatment are? |  |
|  |  |  |
| What factors are most important to your satisfaction with our dental office? |  |
|  |  |  |
| Please share with us why you left your last dental office? |  |
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| **primary physician Information** |
| Patient Name: | Last Date of Visit: |
| Physician: | Clinic/Facility: | Telephone: |

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| **Medical History** |
| General Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor |
| [ ] Y[ ] N | Under a physician’s care now? |  |
| [ ] Y[ ] N | Any hospitalization in the past 5 years? |       |  |
| [ ] Y[ ] N | Any serious illnesses/surgeries? |       |  |
| [ ] Y[ ] N | Use tobacco in any form? If yes, type: |       |  |
| [ ] Y[ ] N | Is pre-medication required before dental visits due to heart condition or artificial joint? |  |
| [ ] Y[ ] N | Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.* |  |
| Female Patients: | [ ] Y[ ] N Currently nursing? | [ ] Y[ ] N Currently pregnant? | Due Date: |       |  |
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| All Patients: Do you have, or have you ever had any of the following? (Check all that apply): | [ ] None |  |
| [ ] Acid Reflux | [ ] Bulimia | [ ]  Heart Murmur | [ ] Respiratory Disease |
| [ ] AIDS/HIV | [ ] Cancer/Malignancy | [ ]  Hepatitis | [ ] Rheumatic Fever |
| [ ] Anemia | [ ] Cerebral Palsy | [ ]  High Blood Pressure | [ ] Sinus Problems |
| [ ] Anxiety | [ ] Chemical Dependency | [ ]  Kidney Disease | [ ] Stroke |
| [ ] Artificial Heart Valve | [ ]  Diabetes | [ ]  Liver Problems | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Dizziness/Fainting | [ ]  Mitral Valve Prolapse | [ ] Thyroid Condition |
| [ ] Artificial Joints | [ ]  Epilepsy/Seizures | [ ]  Pacemaker | [ ] Tuberculosis |
| Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Frequent Headaches | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Ulcers |
| [ ] Arthritis | [ ]  Hearing Problems | [ ] Psychiatric Treatment | [ ] Venereal Disease |
| [ ] Asthma | [ ]  Heart Attack | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Other – please list: |
| [ ] Autism/Asperger’s | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Radiation/Chemo | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ] Bleeding Disorder | [ ] Heart Disease | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |
| All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply): |
| [ ] Aspirin | [ ] Codeine | [ ]  Metal Sensitivity | [ ]  Sulfa Drugs | [ ] None |  |
| [ ] Anesthetic – Local | [ ] Food | [ ]  Nitrous Oxide Sedation | [ ]  Penicillin/Other Antibiotics |
| [ ] Barbiturates | [ ] Latex | [ ]  Sleeping Pills |  |
| [ ] Other – please list: |       |  |
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| **medication information** |
| All Patients: Are you currently taking any of the following? (Check all that apply): | [ ] None |  |
| [ ] Antibiotics/Sulfa Drugs | [ ] Antihistamines/Allergy | [ ] Daily Aspirin | [ ] Blood pressure Medications |
| [ ] Blood thinners | [ ] Cancer/Chemo Medications | [ ] Cortisone/Steroids | [ ] Heart Medication/Digitalis |
| [ ] Insulin | [ ] Nitroglycerin | [ ] Oral Contraceptives | [ ] Osteoporosis Medications |
| [ ] Other Diabetic Medications | [ ] Recreational Drugs | [ ] Thyroid Medications | [ ] Tranquilizers |
| [ ] Other (Please list below **OR** on Following page if space is needed) |
|  |  |  |  |
| Is there anything important about your medical condition we have not asked? [ ] Y[ ] N If yes, please describe: |
|  |       |  |
|  |

|  |  |
| --- | --- |
| **Patient Name:**  | **Date:** |
| **Drug Name** | **Dosage** | **Reason Prescribed** |
|       |       |       |
|       |       |       |
|       |       |       |
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|       |       |       |

**Financial Guidelines**

*We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.*

**Insurance**

**We accept all major dental insurance payments; however we may not be an in network provider for your plan**. If we are not an in-network provider, review your plan details, as in many cases insurance reimbursement is very similar.

* **We are in network for Delta Dental Premier.**
* **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
* **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for co-payment at the time of service.

Initial: \_\_\_\_\_\_\_\_\_\_\_

**Payments**

* **Patient portion orpatient co-pay is due atthe time services are rendered** - unless prior financial arrangements have been made.
* **Payment Information:**
	+ All major credit cards are accepted (Visa, MasterCard, Discover, Amex)
	+ Various financing options with CareCredit®

Initial: \_\_\_\_\_\_\_\_\_\_\_

**Short Notice Cancellation/ Missed Appointments**

* **Please give 2 Business Days’ notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
* **Short Notice Cancellation or missed appointments** will be charged $50 per hour appointment was scheduled.

Initial: \_\_\_\_\_\_\_\_\_\_\_

 **By signing below I acknowledge I have read and understand the agreements above.**

|  |
| --- |
| Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2019

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above 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 health care operations and I 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.

**Signature:**  **Date:**

**Relationship to Patient**: [ ] Self[ ] Parent[ ] Guardian[ ] Other[ ]

**Please list any dependent children under the age of 18 also covered by this acknowledgement:**

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| **Patient consent - payment authorization - signature on file** |
| To the best of my knowledge, allof the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.I hereby authorize payment directly to *Oasis Family Dentistry* of the dental benefits otherwise payable to me.I hereby authorize *Oasis Family Dentistry* to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.I understand and agree that (regardless of my insurance status) **I am ultimately responsible for the balance on my account for any professional services rendered.****By signing below, I acknowledge that I have read and understand the statements mentioned above.**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |