Welcome!

Patient's Full Name: _____ Preferred Name: _____
First Middle Last

Gender ○ M ○ F ○ Non-binary Date of Birth: _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Responsible Party's Name (if different than above): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

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

How did you hear about our clinic? ○ Drive-by ○ Internet Search ○ Social Media ○ Family/Friend: _____
○ Other: _____

Primary Dental Insurance

Policy Holder: _____

Date of Birth: _____

Employer/Group Name: _____

Group Number: _____

Insurance Company: _____

Address: _____

Member ID or SSN: _____

Secondary Dental Insurance

Policy Holder: _____

Date of Birth: _____

Employer/Group Name: _____

Group Number: _____

Insurance Company: _____

Address: _____

Member ID or SSN: _____

Dental History

Date of Last Dental Visit: _____ Date of Last Cleaning: _____

How often do you brush your teeth? _____ How often do you floss? _____

Are you currently experiencing any dental pain or problems now? ○Yes ○No

If yes, please describe: _____

Do your gums bleed when you brush or floss?	○Y ○N	Do you have earaches or neck pains?	○Y ○N
Are your teeth sensitive to cold, hot, sweets or pressure?	○Y ○N	Do you have any clicking, popping, or discomfort in the jaw?	○Y ○N
Does food or floss catch between your teeth?	○Y ○N	Do you brux or grind your teeth?	○Y ○N
Is your mouth dry?	○Y ○N	Do you have sores or ulcers in your mouth?	○Y ○N
Have you had any periodontal (gum) treatments?	○Y ○N	Do you wear dentures or partials?	○Y ○N
Have you ever had orthodontic (braces) treatments?	○Y ○N	Do you participate in active recreational activities?	○Y ○N
Is your home water fluoridated?	○Y ○N	Have you ever had a serious injury to your head or mouth?	○Y ○N

○Yes ○No Have you ever been told to take a pre-medication prior to dental treatment?

○Yes ○No Have you ever whitened your teeth before? If yes, how: _____

○Yes ○No Are you interested in learning about whitening options available?

How do you feel about your smile?_____

_____

POINT Family Dentistry

Medical History

Although dental personnel primarily treat the area in/around your mouth, your mouth is a part of your entire body. Health problems you have, or medication that you take, could have an important relationship with the dentistry you receive.

◯Yes ◯No Are you under a physician's care now? If yes, please explain: _____

_____

◯Yes ◯No Have you ever been hospitalized or had a major operation? If yes, please explain: _____

_____

◯Yes ◯No Have you ever had a serious head or neck injury? If yes, please explain: _____

_____

◯Yes ◯No Are you taking any medications, pills or drugs? Are you taking any vitamins (natural or herbal) and or diet supplements? If yes, please list: _____

_____

Are you allergic to any of the following?

◯Aspirin ◯Penicillin ◯Codeine ◯Local Anesthetics ◯Acrylic ◯Metal ◯Latex ◯Sulfa drugs ◯Other: _____

◯Yes ◯No Do you take, or have you taken prescription medication for weight loss such as Phen-Fen, Pondimen or Redux? If yes to any of the above, did you have a medical exam for heart issues? _____

◯Yes ◯No Have you ever taken bone loss prevention drugs such as Fosamax, Boniva, Actonel, or other similar drugs?

◯Yes ◯No Are you aware of having an allergic (or adverse) reaction to any substance or medication?

◯Yes ◯No Are you on a special diet? _____

◯Yes ◯No Do you use tobacco products? _____

◯Yes ◯No Do you drink alcoholic beverages? If yes, how much alcohol did you drink within past 24 hours? _____

◯Yes ◯No Do you use controlled substances? _____

Women: Are you pregnant? ◯Y ◯N If yes, # of weeks? _____ Taking oral contraceptives ◯Y ◯N Nursing? ◯Y ◯N

Do you have, or have you had, any of the following?

Heart (Surgery, Disease, Attack)	◯Y	◯N	Ulcers	◯Y	◯N	Hepatitis (A, B, C) ____	◯Y	◯N
Chest Pain	◯Y	◯N	Diabetes	◯Y	◯N	Venereal Disease	◯Y	◯N
Congenital Heart Disease	◯Y	◯N	Thyroid Problems	◯Y	◯N	AIDS/HIV Positive	◯Y	◯N
Heart Murmur	◯Y	◯N	Glaucoma	◯Y	◯N	Cold Sores/Fever Blisters	◯Y	◯N
High/Low Blood Pressure	◯Y	◯N	Contact Lenses	◯Y	◯N	Blood Transfusion	◯Y	◯N
Mitral Valve Prolapse	◯Y	◯N	Emphysema	◯Y	◯N	Hemophilia	◯Y	◯N
Artificial Heart Valve/Pacemaker	◯Y	◯N	Chronic Cough	◯Y	◯N	Sickle Cell Disease	◯Y	◯N
Rheumatic Fever	◯Y	◯N	Tuberculosis	◯Y	◯N	Bruise Easily	◯Y	◯N
Arthritis/Rheumatism	◯Y	◯N	Asthma	◯Y	◯N	Liver Disease/Yellow Jaundice	◯Y	◯N
Cortisone Medicine	◯Y	◯N	Hay Fever/Allergies/Hives	◯Y	◯N	Neurological Disorders	◯Y	◯N
Swollen Ankles	◯Y	◯N	Latex Sensitivity	◯Y	◯N	Epilepsy or Seizures	◯Y	◯N
Stroke	◯Y	◯N	Sinus Trouble	◯Y	◯N	Fainting or Dizzy Spells	◯Y	◯N
Diet (Special/Restricted	◯Y	◯N	Radiation Therapy	◯Y	◯N	Nervous/Anxious	◯Y	◯N
Artificial Joints (Hip, Knee, etc.)	◯Y	◯N	Chemotherapy	◯Y	◯N	Psychiatric/Psychological Care	◯Y	◯N
Kidney Trouble	◯Y	◯N	Tumors	◯Y	◯N	Other: _____	◯Y	◯N

In the unlikely event that a member of our staff is exposed to my blood or body fluids through a needle stick, skin cut, or splash to the eyes/mouth area, I agree to have my blood tested (free of charge) for blood borne diseases. ◯Yes ◯No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. 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 the highest quality of dental care to all patients.

Patient/Responsible Party Signature: _____ **Date:** _____

Dentist Signature: _____ ASA: I II III IV

Dental Insurance

Please be prepared to show your current dental insurance card and a valid photo ID at each visit.

Your insurance is a contract between you, your employer (if applicable) and the insurance company. At our practice, we will file your insurance claim for you. As a courtesy, we will assist you with information, however, if you have any additional questions about coverage, please contact your insurance company or human resources department. **Patient is responsible for understanding the terms and limits of his/her benefits.** Treatment recommended by our dental professionals is never based on what your insurance company will pay, but on what our team feels is the best for your overall dental health.

Our goal is to maximize your insurance benefits. Please remember that insurance is not designed to cover 100% of the cost of all types of dental treatment. At the time of treatment, the patient/guarantor is responsible for the estimated portion that the insurance does not cover (also called "copay").

Insurance Signature on File - The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed this particular claim.

Authorized Signature of Covered Person/Employee: _____

Financial Considerations

At our practice, we strive to provide patients with comfortable financing options for affording their dental treatment. Payment arrangements are required before beginning any treatment that is not covered 100% by dental insurance.

- Dental Services provided by our office are an agreement between the patient and the doctor.
- Patients who do not have insurance are required to pay at the time of service.
- Patient portion is due at the time of your appointment. For services that require multiple visits, payment is due at the first visit.
- The parent who requests treatment for the child is responsible for all fees for services rendered.
- I understand that a finance charge of 1.5% will be assessed for accounts over 60 days.
- Delinquency – in the event that your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 35% of the balance due), along with reasonable attorney fees and court costs incurred by this office.
- THIRD PARTY FINANCING:
    - **Care Credit** offers deferred interest for larger treatment plans. A minimum purchase is required, and subject to credit approval. For more information, visit www.carecredit.com
    - **Your Advantage Plan** offers a savings plans for subscribed members up to a 35% discount on preventative or restorative care. www.youradvantageplan.com 1-855-423-8752

Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Initials: _____

Consent for Contact

Point Family Dentistry staff members may contact me by phone, text, or email with reminders to schedule an appointment for any treatment not completed or to schedule a hygiene visit. Initials: _____

Records Release

In the event that I request my records to be transferred to another dental provider, I authorize the release of my records in advance.

Initials: _____

Patient/Responsible Party Signature _____ **Date:** _____

POINT Family Dentistry

Acknowledgement of Receipt of **NOTICE OF PRIVACY PRACTICES** and **CONSENT FOR USE and DISCLOSURE OF HEALTH INFORMATION** & **PATIENT COMMUNICATION**

To the Patient – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Notice of Privacy Practices: You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. *A Copy of our Notice of Privacy Practices is available upon request from this office.* We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. These changes may apply to any of your protected health information that we maintain.

Consent does not expire after one year. By signing this Consent Form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this consent does not expire after one year for 1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of myself; or 2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent. You may obtain a revocation of consent form upon request.

PATIENT CONFIDENTIALITY / COMMUNICATION: It is the office policy of this practice to not release confidential medical and health information regarding your treatment to family members or friends, except for 1) parent or legal guardian; 2) other persons authorized by the patient; 3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment); 4) in emergency situations, or 5) as otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).

If you anticipate that you will need or want your medical or health information to be provided to family members, friends, or caretakers, please sign below so that we can release that information to that person. If you do NOT want any of your medical or health information provided to a family member or friend, please place an "X" in the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later, please confirm in writing.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or Practice may have already released information about you after you gave permission. You understand that cancelling this authorization would not prohibit any release of information by the Practice in reliance to your original authorization.

	Health Care Info	Financial Info
Spouse _____	◯**Yes** ◯**No**	◯**Yes** ◯**No**
Parent _____	◯**Yes** ◯**No**	◯**Yes** ◯**No**
Other _____	◯**Yes** ◯**No**	◯**Yes** ◯**No**

Printed Name _____ **Date:** _____

Patient/Parent/Guardian Signature _____

You are entitled to a copy of this consent upon request.