Total Health Dental

Today's Date_____

Patient Information

Patient Name:_____Preferred Name:_____Date of Birth:_____Gender:

Mailing Address:_____Apt.#_____City:_____State:_____Zip:_____

SS#:_____Home Phone:_____Cell:_____Marital Status:

E-Mail:_____@_____Employer:_____

Occupation:_____Employer Address:_____Employer Phone: _____

Emergency contact:_____Relationship:_____Phone:_____Phone: _____

How were you referred to our office? _____

Primary Insurance Information

Subscriber's Name:_____Date of Birth:_____Employer:

SS#:_____ID #_____Name of Insurance Company:_____

Insurance Address:_____City:_____St:_____Zip:_____Phone: _____

Secondary Insurance Information

Subscriber's Name:_____Date of Birth:_____Employer: _____

SS#:_____ID #_____Name of Insurance Company:_____

Insurance Address:_____City:_____St:_____Zip:_____Phone:

Would you like email and text reminders? Email Y/N Text Y/N

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

HIPAA. I acknowledge that I have been offered a copy of the Notice of Privacy Practices, containing a complete description of the uses and disclosures of my health information. This is simply an acknowledgement of receipt, and nothing more.

Patient Name_____Signature_____

Relationship to Patient_____Date _____

Total Health Dental

OFFICE POLICY

Welcome! Our interest is to provide our patients with the finest possible dental care. As your provider, we advise treatment that is in the best interest of your medical and dental health. Be aware, often, insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs. Following is an overview of our office financial policy we provide to you as a courtesy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. ***As a courtesy***, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement. **Initials_____**

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial down-payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays. **Initials_____**

Copyright: Any comment posted online in any way relating to Our office, doctors or employees will be the sole right and property of Our office and the copyright of the content of the comment, rating, or review is hereby assigned to Our office to utilize at our discretion in order to protect the practice and our patient's anonymity and privacy. We appreciate public praise and comments and reviews.

Initials_____

Payment: Payment in full is required at the time of service. For your convenience, we accept checks, debit, and credit cards, including Visa, Mastercard, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through CareCredit. **Initials _____**

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary. **Initials_____**

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in Our office being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs. **Initials_____**

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $50.00 per hour. **Initials_____**

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Our office.

I have read, understand, and agree to the above.

Printed Name and Signature Responsible Party:

_____

Date: _____

Total Health Dental

Patient Name:_____Date of birth:_____

DENTAL HISTORY

Doctor Use Only

Do you presently have or have you had:

	Yes	No	Unsure
1. Pain or discomfort in the mouth, face, or jaws?	☐	☐	☐
2. Bleeding or sensitive gums?	☐	☐	☐
3. Aching of sensitive teeth?	☐	☐	☐
4. Have you had an injury to your face or jaw?	☐	☐	☐
5. Have you had serious trouble associated with any previous dental treatment?	☐	☐	☐
6. Do you feel nervous or uneasy about having dental treatment?	☐	☐	☐

7. Date of last dental treatment: _____

8. My dental problem NOW is:

_____

_____

MEDICAL HISTORY

8. Have you been a patient in a hospital during the past two years?	☐	☐	☐
9. Have you been under the care of a medical doctor in the past two years?	☐	☐	☐
10. Do you use tobacco products?	☐	☐	☐
11. Do you use alcoholic beverages?	☐	☐	☐
12. Do you use recreational or street drugs?	☐	☐	☐
13. Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs? If so, please list:	☐	☐	☐

Drug: Dose/Frequency: Reason for Taking:

_____

_____

_____

14. Do you have any allergies (i.e., itching, rash, swelling of hands, eyes, or feet), or are you made ill by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications?	☐	☐	☐
15. Have you ever had excessive bleeding requiring special treatment?	☐	☐	☐
16. When you walk upstairs or take a walk, do you ever have to stop because of chest pain?	☐	☐	☐
17. Do your ankles swell during the day?	☐	☐	☐

Doctor Use Only

	Yes	No	Unsure
18. Do you use more than two pillows to sleep?.	☐	☐	☐
19. Do you wake up short of breath?	☐	☐	☐
DO YOU PRESENTLY HAVE, OR HAVE YOU HAD:			
20. High blood pressure?	☐	☐	☐
21 . Heart disease, heart attack, or stroke?	☐	☐	☐
22. Angina pectoris (chest pain)?	☐	☐	☐
23. Heart murmur?	☐	☐	☐
24. Rheumatic fever?	☐	☐	☐
25. Congenital heart disease?	☐	☐	☐
26. Artificial heart valve or artificial joint?	☐	☐	☐
27. Fast, irregular heartbeat?	☐	☐	☐
28. Pacemaker?	☐	☐	☐
29. Scarlet fever?	☐	☐	☐
30. Tuberculosis (TB)?	☐	☐	☐
31. AIDS or HIV antibody?	☐	☐	☐
32. Hemophilia, anemia or other blood disease?	☐	☐	☐
33. Cold sores?	☐	☐	☐
34. Venereal disease (syphilis, gonorrhea, herpes, etc?	☐	☐	☐
35. Breathing problems, such as asthma, emphysema, hay fever, or sinus trouble?	☐	☐	☐
36. Diabetes (low or high blood sugar)?	☐	☐	☐
37. Thyroid disease (low or high hormone level)?	☐	☐	☐
38. Are you on a special diet or have you had a significant weight change in the past year?	☐	☐	☐
39. Stomach problems, ulcers, or irritable bowel?	☐	☐	☐
40. Liver disease, hepatitis, or yellow jaundice?	☐	☐	☐
41. Arthritis or rheumatism?	☐	☐	☐
42. Mental illness depression, epilepsy (seizure), fainting or dizzy spells?	☐	☐	☐
43. Kidney disease or dialysis?	☐	☐	☐
44. Cancer or other tumor?	☐	☐	☐
45. Cancer treatment, such as radiation or chemotherapy?	☐	☐	☐
46. Do you have a history of genetic, congenital, or family type disorder?	☐	☐	☐

Doctor Use Only

47. Do you have any disease, condition or problem not listed? ☐ ☐ ☐

48. Women:

Are you pregnant now? ☐ ☐ ☐

Are you currently using a prescription-type contraceptive? ☐ ☐ ☐

Dental History:

_____
_____
_____
_____
_____

Medical Summary:

_____
_____
_____
_____

To the best of my knowledge, all of the preceding answers are true and correct.

Signature_____

Patient or Guardian ***Relationship to patient***

Signature_____ _____

Reviewing Doctor *Date*

Total Health Dental