NEW PATIENT FORM

Date: **Office:** **Patient:**

Patient Information (Minor: Yes / No)

Full Name: _____ **Prefer to be called:** _____

Birthdate: _____ **Age:** _____ **SS#:** _____ **Sex:** M F

Address: _____

Phone Home: _____ Work: _____ Cell: _____

Email: _____ **Employer:** _____ **Marital status:**_____

Spouse's Name: _____ **# of children under 14:** _____ **# of children above 14:** _____

Emergency Contact: _____ **Emergency Phone:** _____

How did you hear about us: ▢ Social Media ▢ Google ▢ Insurance ▢ Family / Friend ▢ Other

Responsible Party

Name of person responsible for account: _____ **Relationship to patient:**_____

Address: _____

Phone Home: _____ Work: _____ Cell: _____

Employer: _____ **SS#:**_____ **Date of birth:** _____

Preferred payment method: _____

Insurance Information

Insurance Company: _____ **Group #:** _____ **ID#:** _____

Insurance Phone #: _____ **Insurance Address:**_____

Policy Holder's name: _____ **Employer:**_____ **Work Phone:** _____

DOB Policy Holder: _____ **SS#:**_____ **Relation to Patient:** _____

Secondary Dental Insurance: YES NO

Dental History

Previous Dentist: _____ **Previous Clinic:** _____

Times a day you brush: _____ **Times a week you floss:** _____ **Rating of your smile (1-10):** _____

Require antibiotic pre-med: _____

Medical History

Physician: _____ **Office Phone:** _____ **Date of last visit:** _____

Under medical treatment?: Yes No **If yes, explain:** _____

_____

Hospitalized within last 5 year?: Yes No **If yes, explain:** _____

_____

Taking blood thinner?: Yes No **If yes, explain:** _____

_____

Taken Phen Fen? Yes No **Use tobacco?** Yes No **If yes, how long?** _____

Taken Bisphosbhonates?: Yes No **If yes, how long?:** _____ **Controlled substances?** Yes No

Are you allergic to or had reactions to any of the following?

	YES	NO		YES	NO
Local Anesthetics			Penicillin		
Any metals			Latex Rubber		
Codeine			Other _____		

Do you now have or have you ever had any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
High Blood Pressure			Diabetes			Heart Murmur			Mitral Valve Prolapse		
Seizures			Anemia			Thyroid Problems			Tuberculosis		
Liver Disease			Cardiac Pacemaker			Rheumatic Fever			Kidney Disease		
Emphysema			STD			Glaucoma			Radiation Therapy		
Low Blood Pressure			Heart Attack			Swollen Ankles			Epilepsy / Convulsions		
Asthma			AIDS/HIV			Stroke			Fainting		
Heart Disease			Respiratory Problems			Leukemia			Cancer		
Joint Replacement			Stomach Problems			Hay Fever/ Allergies			Hepatitis/Jaundice		

Personal Medication List

Prescription Medication	Purpose or Reason Taken	Dose	Time(s) of Day	Form (liquid, capsule, tablet)	Special instructions

Sleeping and Breathing Health

	YES	NO		YES	NO
Do you usually wake feeling tired or unrested?			Do you habitually snore?		
Do you suffer from waking headaches?			Do you experience daytime drowsiness?		
Has anyone observed you not breathing while sleeping?			Do you have blocked nasal passages?		
Do you grind your teeth while sleeping?			Do you ever wake up choking/gasping?		

Women Only

	YES	NO
Are you Pregnant or think you might be pregnant?		
Are you Nursing?		
Are you taking contraceptives?		

Authorization & Release

	YES	NO
Do you accept to share this information with Professional Dental?		

Signature | Full Name | Relation to patient | Date

Doctor Signature | Doctor Full Name

CONSENT FORM

Date:	Office:	Patient:

I authorize Professional Dental and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an outward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment, items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs for the prevention of osteoporosis, such as Fosamax, Boniva, Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I also acknowledge that all of the preceding answers and information provided on all forms filled out are true and correct. If I ever have any change in my health or there are changes in my child's health, I will inform Professional Dental at the next appointment without fail. If changes are not reported, I agree that any damage incurred will be my sole responsibility, financially and legally. I acknowledge that I have the right to refuse treatment at which time I must sign the proper refusal forms. I agree that I will be responsible for any damage incurred if prescribed treatment is not rendered within the reasonable prescribed amount of time.

I accept Professional Dental Consent Form:

Signature	Full Name	Relation to patient	Date

OFFICE FINANCIAL POLICY

Date:	Office:	Patient:

We are happy you have chosen Professional Dental as your dental provider. We accept many different insurances to benefit our patients. As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon the reimbursement from our patients for the costs incurred in their care, to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that it is their responsibility to provide correct/updated insurance information. All dental services rendered are charged directly to the patient and that he or she is personally responsible for payment of all services. Professional Dental is happy to submit insurance forms and help resolve outstanding claims to the insurance company designated by you. You must understand that not all insurance companies pay in full for estimated services rendered. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.

All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree to terms listed above.

I accept Professional Dental Office Financial Policy: {{acceptfinancialpolicy}}

Signature	Full Name	Relation to patient	Date

HIPAA Compliance Patient Consent Form

Acknowledgement of receipt of notice of privacy practices

Date:	Office:	Patient:

I acknowledge that I have received a copy or had the opportunity to read Professional Dental's Privacy Policy (HIPAA agreement). I hereby agree to abide by the condition outlined herein. (You may refuse to sign this acknowledgment).

	YES	NO
I acknowledge receipt of Professional's Dental Notice of Privacy Practices.		

Signature	Full Name	Relation to patient	Date

For Office Use Only:

☐ Individual Refused to Sign

Other:

Notice of Non-covered / Non-payable Dental Products and Services

At our dental practice, we educate our patients on better/enhanced materials, technology, and medications that can enhance the comfort and longevity of the treatment. It is well-known that INSURANCE WILL NOT PAY for these options. We feel the opportunity to have better/enhanced materials, technology, and medications should remain the patient's choice and should not be dictated by insurance companies.

Because there are no standardized dental treatment codes (CDT Codes) for better/enhanced materials, technology, and medications, they are automatically deemed **"not covered"** and **"not payable"** by insurance companies. We believe in being transparent. We document, with clear descriptions, these better/enhanced services using our own **"C-Codes",** which stay within the doctor/patient relationship and are NOT sent to insurance companies.

Patient Acknowledgment:

I understand that my dental discount/insurance company will not cover or pay for better/enhanced materials, technology, and medications, as documented by C-Codes, performed by my dental provider on my behalf at this time or in the future. By signing below, I acknowledge that I understand and agree that:

1. These better/enhanced materials, technology, and medications provided to me, or that will be provided to me in the future, have been verbally explained to me, and accompanied with a treatment plan, printed informational document(s), procedural consent forms, and/or informational consent with a refusal option on the same page.
2. I have freely chosen to self-pay for these better/enhanced materials, technology, and medications, as documented by C-Codes, knowing they are not covered by my dental discount/insurance plan.

I have read this **"Notice of Non-covered / Non-payable Dental Products and Services"** form and have had the opportunity to ask any questions I may have. Any questions I may have had about this form have been answered to my satisfaction.

Signature	Full Name	Relation to patient	Date