Promise Dental

Our Best for You... Always!

Thank you for choosing Promise Dental. We are committed to providing you with the best dental care possible. If you have any questions or problems filling out the information below, please ask for our assistance. Thank you for entrusting us with your care.

Patient: Mr. Mrs. Ms. Dr. _____ Goes By: _____ (circle one) **M / F**

Address: _____ **Marital Status: Single Married Divorced Separated**

_____ **Full Time Student: Yes / No Level / Grade:** _____

City:_____ **State:**_____ **Zip:**_____ **Where:**_____

Phone: (H) _____ **(C)**_____ **(W)**_____ **Email:**_____

How do you prefer we contact you? **Phone / Email?** _____

SSN: ____ / ___ / _____ DOB: ___ /___ / _____ Age: _____ Driver's License #: _____

How did you hear about our office? **Family / Friend / Co-Worker / Google / Website / Other**: _____

Have you been treated by any of our Doctors or Staff before? **Yes / No Who?** _____

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

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: Mr. Mrs. Ms. Dr. _____ Employer: _____

Address: _____ Position / Title: _____

_____ Work Address: _____

City:_____ State:_____ Zip:_____ _____

SSN: ____ / ___ / _____ DOB: ___ /___ / _____ Age: _____ Driver's License #: _____

Relationship to patient? (Circle one) **Self / Spouse / Father / Mother / Other:** _____

Primary Dental Insurance

Insurance Company Name: _____

Ins. Address: _____ Provider Phone #: _____

_____ Policy Effective Date: _____

Insured Member's Name: _____ Employer: _____

Member ID#: _____ Group #: _____

SSN: _____ DOB: _____

Insured Member's Address: _____ City: _____ State: _____ Zip: _____

Because of the inconsistencies in secondary insurance benefits, we do not accept assignment of secondary benefits. We will gladly file your secondary claim forms for you, and ask that the payments from your secondary insurance company be assigned to you.

Medical – Dental History

Patient Name: _____ **Date:** _____

Physician's Name and Location: _____ **Physician's Phone:** _____

Pharmacy Name and Location: _____ **Pharmacy's Phone:** _____

What is the main reason for your visit today?

Yes / No **Conditions**

- ◯ ◯ Abnormal Bleeding
- ◯ ◯ Alcohol Abuse
- ◯ ◯ Allergies
- ◯ ◯ Anemia
- ◯ ◯ Angina Pectoris
- ◯ ◯ Arthritis
- ◯ ◯ Artificial Bones
- ◯ ◯ Artificial Heart Valve
- ◯ ◯ Asthma
- ◯ ◯ Blood Transfusion
- ◯ ◯ Cancer – Chemotherapy
- ◯ ◯ Colitis
- ◯ ◯ Congenital Heart Defect
- ◯ ◯ Cosmetic Surgery
- ◯ ◯ Diabetes
- ◯ ◯ Difficulty Breathing
- ◯ ◯ Drug Abuse
- ◯ ◯ Emphysema
- ◯ ◯ Epilepsy
- ◯ ◯ Fainting Spells
- ◯ ◯ Fever Blisters
- ◯ ◯ Frequent Headaches
- ◯ ◯ Glaucoma
- ◯ ◯ HIV/AIDS
- ◯ ◯ Hay Fever
- ◯ ◯ Heart Attack
- ◯ ◯ Heart Surgery
- ◯ ◯ Hemophilia
- ◯ ◯ Hepatitis
- ◯ ◯ High Blood Pressure
- ◯ ◯ Kidney Problems
- ◯ ◯ Liver Disease
- ◯ ◯ Low Blood Pressure
- ◯ ◯ Mitral Valve Prolapse
- ◯ ◯ Pace Maker
- ◯ ◯ Pneumocystis
- ◯ ◯ Psychiatric Problems
- ◯ ◯ Radiation Therapy
- ◯ ◯ Rheumatic Fever
- ◯ ◯ Seizures
- ◯ ◯ Shingles
- ◯ ◯ Sickle Cell Disease
- ◯ ◯ Sinus Problems
- ◯ ◯ Stroke
- ◯ ◯ Thyroid Problems
- ◯ ◯ Tuberculosis
- ◯ ◯ Ulcers
- ◯ ◯ Venereal Disease
- ◯ ◯ Yellow Jaundice

Yes / No **Allergies**

- ◯ ◯ Aspirin
- ◯ ◯ Codeine
- ◯ ◯ Dental Anesthetics
- ◯ ◯ Erythromycin
- ◯ ◯ Jewelry
- ◯ ◯ Latex
- ◯ ◯ Metals
- ◯ ◯ Penicillin
- ◯ ◯ Tetracycline
- ◯ ◯ Other Allergies:

◯ ◯ **Have you ever had to be pre-medicated prior to dental treatment?**

◯ ◯ **Do you smoke or use tobacco?**

Yes / No Male ◯ Female ◯

If you are Female, are you...

- ◯ ◯ Taking birth control
- ◯ ◯ taking hormone medication
- ◯ ◯ Pregnant
- ◯ ◯ Nursing

◯ ◯ Do you have any other medical condition that we have not covered in this list? Explain...

◯ ◯ Are you presently under the care of a physician? If yes, for what?

Your Height: _____

Your Weight: _____

Your Age: _____

For Office Use ONLY
Blood Pressure
Heart Rate

Dental History

When was your last dental visit?

Yes / No

- ◯ ◯ Were x-rays taken?
- ◯ ◯ Were your teeth cleaned at that time?
- ◯ ◯ Do you have a well (or private) water system?
- ◯ ◯ Does your water have fluoride in it?
- ◯ ◯ Have you ever been treated for gum disease?
- ◯ ◯ Do you grind your teeth?
- ◯ ◯ Are your teeth sensitive?
- ◯ ◯ Does your jaw click or pop?
- ◯ ◯ Have you experienced any pain or soreness in the muscles of your face or around your ear?
- ◯ ◯ Do you have dental implants?
- ◯ ◯ Are you happy with your smile?

Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I am responsible to inform this office of any change in my health history.

_____

Signature

_____

Date

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Prescription and Over-the-Counter Drug Information and Interactions

Patient Name: _____ **Date:** _____

It is very critical that you accurately fill out the information below for the safety of your health. We want to provide the best care for you. Please take the time to give us this information. You should also keep a copy of this for you other health care providers and a copy in your purse of wallet for emergencies... Thank you!

Prescription Name	Dosage & Frequency	Medical Conditions
Example: Lipitor	20 mg once daily	High Cholesterol

Over-the-Counter Drugs	Dosage & Frequency	Reason for taking
Example: Baby Aspirin	Twice daily AM/PM	Heart Clog prevention

Allergic to:	How does it affect you?
Example: Penicillin	Anaphylactic Shock/ Hives

The Prescription and Over-the-Counter medications listed above are an accurate reflection. Further, I have indicated accurately any allergies that I have, or have been informed by medical personnel or family, that I might have. Also, I have included any illegal or unauthorized self-medications above to protect my health.

Print

_____

Signature

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Financial Policy

Patient Name: _____ Date: _____

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the dentist. Payments of services are due at the time services are rendered. We accept cash, credit cards, and approved financing through Care Credit.

We may file your insurance claim for you as a courtesy and may accept assignment of insurance benefits. However, you must understand that:

1. **Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and usual and customary charges. Our involvement will be limited to supplying factual information to facilitate claim processing.**
2. **All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.**
3. **Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment.**
4. **I understand that employees of promise Dental are not representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company.**
5. **I understand that full payment needs to be made within thirty days, by me or my insurance company; that failure to do so will be considered delinquent and collection proceedings will begin. I further agree that I am responsible for any additional fees incurred if my account is placed with a collection agency or attorney, including court or legal costs.**
6. **There will be a fee charged for returned checks**
7. **I authorize payment from my insurance carrier be made directly to the dentist.**
8. **I authorize this office to release necessary medical or dental information.**

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so we may assist you in management of your account. We have a number of different financial arrangement options available.

Fixed or removable prosthetics such as dentures, crowns, bridges, or partial dentures are understood to be a product that is uniquely suited to each particular patient. The full amount contacted for such services is therefore, considered to be due and payable when the initial impression is made. Prosthetics must be seated in a timely manner to insure your comfort, and proper fit. If you fail to have your prosthetics permanently seated within 60 days from the date of the impression, a second impression must be made and you will be charged an additional amount. All x-rays taken are part of our permanent records. There is a duplication charge for any x-rays removed from this office.

We accept insurance for payment for the covered portion; however, you must pay your portion at the time services are rendered. I realize that the treatment options which are not covered by my dental plan are my financial responsibility. Cosmetic, upgraded services, or extended warrantees, etc. are not a "covered service" and are "without recourse" from my insurance/ third party carrier.

Thank you for choosing Promise Dental as your dental care provider. We appreciate your trust in us and the opportunity to serve you!

Responsible Party Signature _____

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Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____ , have received a copy of this office's Notice of Privacy Practices.
(print full name)

Signature _____ *Date* _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____ , authorize the following person(s) to have access to information covered under the Privacy Practice regarding my care.

_____	_____
(please print name)	(relationship)
_____	_____
(please print name)	(relationship)
_____	_____
(please print name)	(relationship)

Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please, specify)

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Cancellation Policy

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all our patients. **Please allow at least 48 hours notice for any cancellation or rescheduling of appointments so that we may have the opportunity to offer that time to another patient.**

Patients who cancel or reschedule their appointment without proper notice will be charged a missed appointment fee of $50.00.

We reserve the right to dismiss a patient after the third failed appointment.

If you are more than 15 minutes late to your scheduled appointment, you may be asked to wait until the Doctor is available or to reschedule your appointment.

Responsible Party Signature _____ ***Date*** _____