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PATIENT INFORMATION

Patient: ____________________
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:
____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME
____
SCHOOL/LOCATION

Patient Date of Birth: ____________ Patient SSN: ____________

Address: ____________________
MAILING ADDRESS
____
ADDRESS LINE 2
____
CITY ST ZIP CODE

HOME: ____________
CELL: ____________
OTHER: ____________

E-Mail: ____________________

Referral? ☐Yes ☐ No Referred by: ____________________

Referral Source? Family/Friend____ Facebook/social media____ Website____
Google/Web search____ Radio/Theater____ Newspaper____ Other____________________

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

____________________ Tel: ____________
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: ____________ Occupation: ____________
Address: ____________________
ADDRESS LINE 1
____
ADDRESS LINE 2
____
CITY ST ZIP CODE

WORK: ______ X ______
DIRECT: ____________
OTHER: ____________
PAGER: ____________
FAX: ____________

E-Mail: ____________________

INSURANCE INFORMATION

Subscriber: ____________________
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: ____________ Subscriber SSN: ____________
Subscriber Employer: ____________________
Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER: ____________________
Group/Policy No.: ____________ ID No.: ____________
Address: ____________________
____

TEL: ____________
TOLL-FREE: ____________
FAX: ____________

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?

☐Y☐N Any hospitalized or had a major operation in the past 5 years?

☐Y☐N Have you ever had a serious head/neck injury?

☐Y☐N Use tobacco in any form? If Yes, Type:

☐Y☐N Do you or have you taken Fosamax, Boniva, Actonel or any other meds containing bisphosphonates?

☐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:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐AIDS/HIV
☐ALZHEIMER'S
☐ANEMIA
☐ARTHRITIS/GOUT
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ASTHMA
☐BLOOD DISEASE
☐BREATHING PROBLEMS
☐BRUISE EASILY
☐CANCER/MALIGNANCY
☐CHEMO/RADIATION
☐CHEST PAIN
☐COLD SORES
☐CONGENITAL HEART DISEASE
☐CONVULSIONS
☐CORTISONE MEDICINE
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐DRUG ADDICTION
☐EPILEPSY/SEIZURES
☐EXCESSIVE BLEEDING
☐FREQUENT HEADACHES
☐GENITAL HERPES
☐HEART ATTACK/FAILURE
☐HEART DISEASE/TROUBLE
☐HEART MURMUR
☐HEART PACEMAKER
☐HEPATITIS A, B, OR C
☐HERPES
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LEUKEMIA
☐LIVER PROBLEMS
☐LOW BLOOD PRESSURE
☐LUNG DISEASE
☐OSTEOPOROSIS
☐OTHER – PLEASE LIST:
☐PAIN IN JAW JOINTS
☐PSYCHIATRIC TREATMENT
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SCARLET FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACRYLIC
☐ASPIRIN
☐ANESTHETIC – LOCAL
☐OTHER – PLEASE LIST:
☐CODEINE
☐LATEX
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

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.

- **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.

- **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.

- **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 copayment at the time of service.

Payments

-
- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.

- **Payment Information:**
  - Cash
  - Check*
  - Most major credit cards are accepted (Visa, MasterCard, Discover),
  - We also accept CareCredit® and CitiHealth Card®

- **Balances left over 60 days will incur a 1.5% minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

*There will be a $50 fee on all returned checks. We will attempt to notify you. If not picked up within 10 days, the check will be turned over to the District Attorney's office for collections, unless other arrangements have been made.

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 I have read and understand the guidelines above.

Signature: ___________________________________ Date: ____________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

PATIENT CONSENT– SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Dr. Davis of the dental benefits otherwise payable to me.

I hereby authorize Dr. Davis 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.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: ____ Date:______________________

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list:

APPOINTMENT POLICY AGGREEMENT

Laverne Dental Center is dedicated to provide our patients with quality care and is pleased to reserve your appointment time exclusively for you. We attempt to schedule appointments that are most convenient for you and that fit your personal schedule.

Because we reserve time exclusively for each patient, we ask that you make every effort to not change your reserved appointment. If you find that you cannot keep your scheduled appointment, we require a **minimum 24 hour notification**. This allows us time to fill your appointment with other patients awaiting treatment. When appointments are failed or cancelled without notice, that time is permanently lost.

We understand that there are unforeseen circumstances that can cause appointments to be missed without 24 hours notice; we understand and will take this into consideration. To maintain the most efficient schedule for all of our patients, our Appointment Policy is as follows:

- As a courtesy, our staff attempts to confirm appointments before the scheduled date and time by the methods of text and email, as well as 24 hours before. If you do not confirm by text or email, we will call you the day before. **If we do not hear back from you by 4:00pm the day prior to your appointment, the reserved time will be cancelled and given to the next patient in need of treatment.**
- Late arrivals cause schedule delays for those patients who arrive promptly for their appointments. More than 15 minutes late will count as a failed appointment and will be noted in your chart. Late arrivals will be worked into the schedule **ONLY IF TIME ALLOWS** or rescheduled for another day.
- Patients with more than 2 failed appointments **will be required to PREPAY for services before future appointments will be scheduled**.
- Should the next appointment be broken without following the above guidelines, Laverne Dental Center reserves the right to charge a $50 missed appointment fee.

We value your time as a patient, and respectfully ask that you do the same with ours and other patients in our practice.

I understand this Appointment Agreement and agree to follow the terms of this policy.

____

Patient Name (Please print)

____ ____________________

Patient Signature Date