Welcome to Dental Health Experts – Tell Us about Yourself

Name ____ ☐ Male ☐ Female
Last First MI Preferred

Address________________________________ Apt_______City_________________ State _____ Zip __________

SSN _________-_______-____________ DOB _______________ E-mail ___________________________________

Home Phone ____________________ Work Phone ____________________ Cell Phone _____________________

Employer ____ Occupation ______________________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office? ____

How do you prefer to be contacted for appointment confirmation? (circle preference) Phone E-mail

Insurance – Subscriber Information

Name ________________________________ Relationship ___________________ DOB ___________________

SSN/ID ________________________ Employer ________________________Group Number__________________

Insurance Company Name _____________________________________ Phone Number ___________________

Address_______________________________________City___________________ State _____ Zip ____________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dental Health Experts all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the used of this signature on all insurance submissions.

Responsibility Party Signature ____________________________ Relationship ____________ Date ________________

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

____

Patient Signature (or legal guardian)

DENTAL HEALTH EXPERTS

Medical History

Patient Name ____

Are you currently under the care of a physician? ☐ Yes ☐ No Date of last visit ____________________

Physician's name ______________________________ Physician's phone number ____________________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor Do you use tobacco in any form? ☐ Yes ☐ No

Have you ever had any metal rods, pins, or implants placed? ☐ Yes ☐ No Where? ____________________

Are you taking any medications? ☐ Yes ☐ No Please list each medication: ____________________

____

Have you ever had any surgical procedures? ☐ Yes ☐ No Please list each procedure: ____________________

____

Check Yes or No for Each Condition Listed

Yes	No	Condition		Yes	No	Condition		Yes	No	Condition
		Abnormal Bleeding				Glaucoma				Sickle Cell Disease
		Alcohol Abuse				HIV-AIDS				Sinus Problems
		Allergies – Seasonal				Heart Attack				Stroke
		Anemia				Heart Murmur				Thyroid Problems
		Angina Pectoris				Heart Surgery				Tuberculosis
		Arthritis				Hemophilia				Ulcers
		Artificial Heart Valve				Hepatitis A				
		Asthma				Hepatitis B				
		Blood Transfusion				Hepatitis C		**Yes**	**No**	**Allergies to:**
		Cancer				High Blood Pressure				Codeine
		Chemotherapy				Joint Replacement				Dental Anesthetics
		Colitis				Kidney Problems				Erythromycin
		Congenital Heart Defect				Liver Disease				Jewelry
		Diabetes				Low Blood Pressure				Latex
		Difficulty Breathing				Mitral Valve Prolapse				Metal
		Drug Abuse				Pace Maker				Penicillin
		Emphysema				Psychiatric Problems				Tetracycline
		Epilepsy				Radiation Therapy				Sulfa
		Facial Surgery				Rheumatic Fever				
		Fainting Spells				STD		**Yes**	**No**	**If Female, please answer**
		Fever Blisters				Seizures				Taking birth control pills?
		Frequent Headaches				Shingles				Pregnant? # weeks_____
										Nursing?

Nearest relative not living with you ______________________________ Phone # ____________________

I certify that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

______________________________ ____________________
Signature Date

______________________________ ____________________
Reviewed by Date

DENTAL HEALTH EXPERTS

Dental History

How may we help you today? ____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Where? ________________________________

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Are you under stress? (new job, moving, relationship) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

What would you like to change about your smile? ____

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times a day do you brush? _____________ How many times per week do you floss? ______________

Are your teeth sensitive to heat, cold, or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental visit? _______________________________________

When was your last professional dental cleaning? __________________________

Why did you leave your previous dentist? ____

How can we accommodate you better during your dental visits? ____

Here at Dental Health Experts we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your appointment.

Tooth Whitening	Veneers/Lumineers	Invisible Braces
Partials/Dentures	Smile Makeover	Bonding
Sealants	Crown & Bridge	Implants/Implant Crowns
Night/Sport Guards	Replacing Missing Teeth	

HIPAA Consent

I, ____ hereby authorize Dental Health Experts to use and disclose in any form or format a copy of my dental records bus only as follows. A photo or electronic copy of this signed, dated authorization shall be as effective as the original.

Dental Health Experts may use and disclose the following information to my dental or health insurance provider for the purpose of filing dental or medical claims and/or my physician or health care specialist for the purpose of obtaining medical clearance or information for surgery.

I specifically authorize Dental Health Experts to obtain, use, and disclose the following types of super-confidential information (initial where appropriate):

________ HIV records (including HIV test results) and sexually transmitted diseases;

________ Alcohol and substance abuse diagnosis and treatment records;

________ Psychotherapy records.

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

The undersigned does hereby release, hold harmless, and agree to indemnify Dental Health Experts, its employees, and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until the practice is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that Dental Health Experts has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization.

______________________________ Printed Name	______________________ Date
______________________________ Signature	______________________ Date

OR -- Patient's Representative

______________________________ Printed Name	______________________ Date
______________________________ Describe Authority	
______________________________ Signature	______________________ Date

Financial Policy

Dental Health Experts requires all patients to make financial arrangements with us before we provide treatment. By signing this policy, you are affirming that you have read, understand, and agree to the following statements:

1. I understand that payment in full is due at the time of service for me and any party for whom I am financially responsible.
2. I understand that Dental Health Experts will maintain a copy of my government-issued photo identification (driver's license, passport, or state-issued ID) for record keeping purposes.
3. I understand that I may be asked to pay, in advance for major services such as fillings, extractions, crowns, etc.
4. I understand that payment options available to me are cash, check, or major credit card (Visa, MasterCard, American Express, or Discover).
5. I understand that I will be charged the maximum service charge allowed by law for any returned check, electronic authorization, or any debit sent or provided to Dental Health Experts.
6. I understand that third-party financing is available to me through Care Credit, Compassionate, Springstone, or Lending Tree; all financing is subject to approval by the lender. A credit check is required.
7. I understand that Dental Health Experts is not a preferred provider with any insurance company.
8. I understand that insurance claims will only be filed if I provide all information related to my dental insurance, including my social security number to Dental Health Experts. If I choose not to provide Dental Health Experts with my social security number, I understand that I must pay in full for all services rendered.
9. In the event that Dental Health Experts is unable to verify my insurance benefits, payment in full will be required and documentation will be provided to me that would allow me to file a claim for reimbursement.
10. I understand that Dental Health Experts will file my dental insurance claim as a courtesy and accept assignment of benefits from my insurance company as partial payment for services rendered. I understand that benefits may be reduced based on limitations of my insurance carrier.
11. I understand that benefits quoted are only and ESTIMATE and not a guarantee of payment. Benefits quoted are based on information provided by my insurance company.
12. I understand that Dental Health Experts will file my claim(s) a maximum of two (2) times per appointment and that any further insurance appeal is solely my responsibility.
13. I understand that I will be responsible for any fees not paid by my insurance company within sixty (60) days. Reasons for non-payment include, but are not limited to procedure denial, policy deductibles, maximum allowable annual benefits, frequency limitations, usual and customary (UCR) benefits, procedural limitations, or lifetime benefit limitations.
14. I understand that if I opt to discontinue treatment for a procedure after treatment has started, I will be responsible for paying for the doctor's time, materials used, and associated lab fees. These fees will be deducted from any refund that I may be entitled to as a result of prepayment for the requested services.
15. I understand that all account balances over 30 days old will incur a monthly interest rate charged at the maximum legal rate allowed.
16. I understand that I must inform Dental Health Experts, in writing, of any questions or disputes regarding my treatment or charges in a timely manner but not more than 30 days from either the completion of treatment or receipt of the statement of charges. I agree to work with Dental Health Experts to resolve such matters through an informal mediation process rather than through civil litigation.
17. I understand that Dental Health Experts may report delinquent payments to a credit rating bureau, refer my account to a collection agency, and/or take legal action against me for payment in full plus monthly interest, applicable legal fees, attorney's fees, and court costs.
18. I understand that unless patient records are sent directly to another provider, the charge for copies of x-rays is $25; there is a separate $25 fee for copies of treatment records.
19. I understand that Dental Health Experts can charge a fee for appointments that I change with less than 48 hours notice which includes appointments that I do not keep. After two broken appointments, the dentist retains the right to discontinue elective treatment and to dismiss me from the practice.

______________________________ Patient Name

____________________ Date

______________________________ Signature of Patient or Guardian