Adult New patient Packet

Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

DENTAL INFORMATION

Please mark your responses to the following questions

	Yes	No
Do your gums bleed when you brush or floss?	○	○
Are your teeth sensitive to col d, hot, sweets or pressure?	○	○
Is your mouth dry?	○	○
Have you had any periodontal (gum) treatments?	○	○
Have you ever had orthodontic (braces) treatment?	○	○
Have you had any problems a ssociated with previous denta l treatment?	○	○
Do you know if your home wat er supply fluoridated?	○	○

	Yes	No
Are you currently experiencing dental pain or discomfort?	○	○
Do you have earaches or neck pains?	○	○
Do you have any clicking, pop ping or discomfort in the jaw?	○	○
Do you brux or grind your teet h?	○	○
Do you have sores or ulcers in your mouth?	○	○
Do you wear dentures or parti als?	○	○
Do you participate in active re creational activities?	○	○
Have you ever had a serious in jury to your head or mouth?	○	○

Date of your last dental examv (estimate is fine): _____ Date of last dental x-rays(estimate is fine): _____ What was done at that time? _____ What is the reason for your dental visit today? _____ How do you feel about your smile? _____

MEDICAL INFORMATION

Please mark your response to indicate if you have or have not had any of the following diseases or problems.

Are you taking or have you recently taken any prescription or over the counter medicine(s)?

Medication Name:

Comments/Dosage:

Do you use tobacco (smoking, snuff, chew, bidis)?

- ○ Yes
- ○ No

If so, how interested are you in stopping?

Do you drink alcoholic beverages?

- ○ Yes
- ○ No

WOMEN ONLY Are you:

	Yes	No
Pregnant?	○	○

If Pregnant Number of weeks:

Allergies

- ☐ Amoxicillan
- ☐ Clindamycin
- ☐ Eggs
- ☐ Flouride
- ☐ Latex
- ☐ Local anesthetic
- ☐ Milk
- ☐ Nuts
- ☐ Peanuts
- ☐ Penicillin or other antibiotics
- ☐ Pollen Dust
- ☐ Seasonal
- ☐ Soy

Problems

- ☐ (TMJ) pain/jaw discomfort
- ☐ ADD / ADHD
- ☐ ADHD
- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Anxiety/Nervousness
- ☐ Asthma
- ☐ Autism
- ☐ Bed Wetting
- ☐ Bleeding disorder/Hemophilia
- ☐ Cardiovascular disease
- ☐ Celiac disease
- ☐ Chemotherapy
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Heart Attack/Failure
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hormone imbalance or deficiency
- ☐ Infective endocarditis
- ☐ Irregular Heartbeat
- ☐ Kidney disease
- ☐ Lupus
- ☐ Memory Loss/Alzheimer's Disease
- ☐ Nursing
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Osteoporosis / osteopenia?
- ☐ Other
- ☐ Other Allergies
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Palpitations
- ☐ Pneumonia
- ☐ Pregnant/planning
- ☐ PREMEDICATION NEEDED
- ☐ Radiation Treatments
- ☐ Rheumatoid arthritis
- ☐ Sensory Disorder
- ☐ Sexually transmitted disease
- ☐ Sickle Cell Disease
- ☐ Sjögren's syndrome
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Ulcers

Do you have any disease, condition, or problem not listed above that you think I should know about?

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

- ☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

Sign

Dental Insurance

Subscriber First Name:

Subsriber Last Name:

Subscriber DOB:

SS#:

Relationship to Policy Holder:

Employer:

Insurance Company Name:

Phone #:

Subscriber ID:

Group #:

Insurance Card - Front

No File Uploaded

Insurance Card -Back

No File Uploaded

Driver License/ID Front

No File Uploaded

Driver License/ID Back

No File Uploaded

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient:

Financial Policy

•FULL PAYMENT IS DUE AT TIME OF SERVICE.

Insurance: Coverage and Co-pays

We provide insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by our team regarding his/her remaining benefit in any such benefit period. For covered services, all co-pays and deductibles must be paid on the day of treatment. Since your insurance company may not cover all costs, we require that you pay any percentage of your balance not paid by your insurance on the day of treatment. For services that are not covered by your insurance, we require that you pay the entire fee the day of your treatment We will attempt to answer any questions we can about your insurance and, to the extent practicable, assist you with insurance billing issues. However, your insurance contract is an agreement between you and your insurance carrier to which we are not a party. In the event that your insurance company does not pay any amounts due for your care, you agree you are financially responsible for such amounts, and that you will pay such amounts due for your care.

Patients Without Insurance

For patients without insurance coverage, you will be responsible for payment on the day of treatment. If you are not able to pay in full, or if your treatment requires several visits, you will be issued an invoice and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy/Reschedules

Our office requires at least 48 hours advance notice to cancel your appointment. *This does not include Friday-Sunday changes. Office hours are Monday-Thursday 9:00 AM-5:00 PM If you are needing to make changes to your appointment you must notify the office by: Monday Appt: Wednesday before 5pm Tuesday Appt: Thursday before 5pm Wednesday Appt: Monday before 5pm Thursday Appt: Tuesday before 5pm *We reserve the right to charge a reasonable fee ($50), up to the amount normally due for our services, for patients who do not give advance notice to cancel an appointment.

By checking this box I acknowledge the following:

☐ I have read and understood the Cancellation/ No Show and Rescheduling Policy as stated above.

Collections

A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on your account including all attorneys' fees, interest, and late fees.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature:

Sign

Consent for Use and Disclosure of Protected Health Information

SECTION A: PATIENT GIVING CONSENT

☐ Initial Acknowledgement of Privacy Practices

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to protected health information that we maintain.

Authorization to Disclose Protected Health Information

I hereby authorize Willow Family Dentistry, to disclose my protected health information to health care providers and the following below:

Names, Phone Numbers & Relationship for Authorization of individuals (If none: N/A):

Description of Information to be disclosed:

The information to be disclosed includes: Treatment History Full Dental Records (All documents, notes & x-rays requested) Billing & Account information

Checkboxes

☐ I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature and Acknowledgement

I hereby acknowledge that I have read and understand the contents of this authorization form. I consent to the release of my dental health information as described above in accordance with the provisions of HIPAA. I understand that I may ask for clarification of this authorization or additional information if necessary.

Signature

Sign

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____