Patient Information (CONFIDENTIAL)

How did you hear about us?____________________

Neighborhood Dental can now confirm appointments by Email or Text. Please check your preference:

❑ Email ❑ Text ❑ Home Phone ❑ Cell Phone

Are you willing to be on a quick-fill list? ❑ Yes ❑ No

Patients receive a 10% discount off treatment or $20 credit for routine exam/cleaning when taking a quick fill appointment. You may receive numerous phone calls when there are cancellations.

Name __________ Birthdate __________ Home Phone __________ ❑ M ❑ F

Address __________ City __________ State _____ Zip _____

Email __________ SS#__________ Cell Phone __________

If Full Time Student, Name of School/College __________ City __________ State _____

Patient or Parent/Guardian's Employer __________ Work Phone __________

Business Address __________ City __________ State _____ Zip _____

Spouse or Parent/Guardian's Name __________ Employer __________ Work Phone __________

Person to contact in case of emergency __________ Phone __________

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account __________ Relationship to Patient __________

Address __________ Home Phone __________

Birthdate __________Email __________ Cell Phone __________

Employer __________ Work Phone __________ SS#__________

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured __________

Relationship to Patient __________

Birthdate __________

SS#/ID# __________

Name of Employer __________

Insurance Company __________

Group # __________

Policy ID # __________

SECONDARY INSURANCE

Name of Insured __________

Relationship to Patient __________

Birthdate __________

SS#/ID# __________

Name of Employer __________

Insurance Company __________

Group # __________

Policy ID # __________

Patient Dental History

Name of Previous Dentist and Location __________Date of Last Exam __________

1. Have you ever been diagnosed with periodontal disease?__________

____

2. How would you rate your smile on a scale from 1-10?__________

3. What changes would you make to improve your smile?__________

Over Please...

Patient Medical History

Physician ______________________ Office Phone ______________ Date of Last Exam __________

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑

If yes, please explain: ______________________

____

____

____

____

	Yes	No
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑

If yes, what medication(s) are you taking? ______________________

____

____

____

____

4. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other Antibiotics (Please list)	❑	❑

____

	Yes	No
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g Nickel, Mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (Please list)	❑	❑

____

____

____

	Yes	No
5. Have you ever taken Fen-Phen/Redux?	❑	❑
6. Do you use tobacco?	❑	❑
7. Do you use controlled substances?	❑	❑
8. Are you taking any blood thinners?	❑	❑
9. Are you taking any bisphosphonates?	❑	❑
10. Do you have Hepatitis or Jaundice?	❑	❑
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑	❑

12. Do you have or have you had any of the following?

	Yes	No		Yes	No
High Blood Pressure	❑	❑	Emphysema	❑	❑
Heart Attack	❑	❑	Cancer	❑	❑
Rheumatic Fever	❑	❑	Arthritis	❑	❑
Fainting/Seizures	❑	❑	Stroke	❑	❑
Asthma	❑	❑	Tuberculosis	❑	❑
Low Blood Pressure	❑	❑	Radiation Therapy	❑	❑
Epilepsy/Convulsions	❑	❑	Liver Disease	❑	❑
Leukemia	❑	❑	Heart Trouble	❑	❑
Diabetes	❑	❑	Respiratory Problems	❑	❑
Kidney Disease	❑	❑	Mitral Valve Prolapse	❑	❑
AIDS or HIV Infection	❑	❑	Joint Repl or Implant	❑	❑
Thyroid Problem	❑	❑	Other (please list)	❑	❑
Heart Disease	❑	❑	______________		
Cardiac Pacemaker	❑	❑	______________		
Heart Murmur	❑	❑	______________		
Anemia	❑	❑	______________		

13. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

HIPAA Privacy Practices

I have read a copy of this office's Notice of Privacy Practices. By signing this form, I consent for your office to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient *(or Parent/Guardian of Minor)* ______________________ Date__________

I give my permission to discuss my dental treatment (including but not limited to: Treatment, Scheduling, Billing, Insurance, etc.) with the following: ______________________

____

Signature of Patient *(or Parent/Guardian of Minor)* ______________________ Date__________

Our Mission at Neighborhood Dental is to save patients pain, time, and money. Before any work is performed, we will discuss treatment and financial options so there are no surprises.

Payment for your portion of the fees, is required on the day services are rendered. We accept cash, personal checks, money orders, Mastercard, Visa, Discover, and Care Credit.

Care Credit is available in our office and provides extended payment plans with prior credit approval.

Emergency clients without insurance, who are new to our office, should expect to pay their portion, in full, upon check-in.

Dental insurance is a contract between the employer and the patient. The extent of coverage varies greatly between plans and sometimes even with a single plan. We only recommend treatment according to our standard of care, regardless of insurance coverage. ANY BALANCE NOT COVERED BY YOUR DENTAL INSURANCE IS YOUR RESPONSIBILITY. We will submit your insurance claim as a courtesy for you. If your insurance pays differently than our estimate we will either refund you or the remainder will be due within 30 days of the first statement date.

Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening should arise. The clinic requires a notice of at least 24 hours if the patient is unable to keep the reserved appointment time. You may be charged for missed appointments or cancellations with less than 24 hours notice. If a patient “no-shows” three appointments, we will move you to a same-day-only list.

In the case of separated or divorced parents of minors, who are responsible for a portion of the cost of a child(ren)’s treatment: The parent who brings the child in to the appointment is responsible for paying the patient portion on the day of service.

I have read and understand this financial policy.

______________________	______________________	____________
Printed Name	Signature	Date

Nuestra mision en Neighborhood Dental es ahorrarle a nuestros pacientes dolor, tiempo y dinero.

Antes de empezar cualquier tratamiento hablaremos con usted de las opciones que tiene, tanto financieras como de tratamiento para que no tenga sorpresas.

Su porción de pago es requerida el dia que se le reálice el tratamiento, aceptamos efectivo, cheques personales, giros postales, MasterCard, Visa, Discover y Care Credit.

Care credit es disponible en nuestra oficina y ofrece extendidos planes de pago con una pre-aprobación de credito.

Pacientes de emergencia sin aseguranza, que son nuevos a nuestra oficina son requeridos a pagar el costo total de la visita al registrarse.

La aseguranza Dental es un contrato entre usted y su empleador, la cobertura varia altamente dependiendo el plan que tenga. Nuestra clinica solo recomienda tratamiento de acuerdo a nuestros estandares de cuidado. Muy aparte de si tiene cobertura dental o no. CUALQUIER BALANCE QUE SU ASEGURANZA DENTAL NO CUBRA ES SU RESPONSABILIDAD.

Nosotoros enviaremos todos los costos de su visita a su aseguranza como una cortesia hacia usted. Si su aseguranza paga una cantidad diferente a lo que nosotros teniamos calculado por ejemplo, si usted pago de mas, nosotros le devolveremos su dinero, o si pago menos necesitamos que pague el balance dentro de los 30 dias que se le mando la primera factura.

Tiempo para su cita es reservado exclusivamente para usted y para beneficiarlo a usted nuestro apreciado paciente. Talvez lo llamemos para ofrecerle mover su cita si algo sale disponible antes de su cita planeada. Tambien nuestra clinica require que nos avise 24 horas antes de su cita si no va a poder asistir, ya que se le puede cobrar por citas perdidas o canceladas en menos de 24 horas. Si el paciente pierde 3 citas desafortunadamente ya no le podremos hacer citas, lo tendremos que poner en nuestra lista de citas para el mismo dia.

En caso de padres separados o divorciados de menores de edad, el padre que acompañe al menor el dia de la cita sera responsable de pagar la porción de la cita el dia que se le realizo el servicio.

Eh leído y entiendo la poliza financiera.

____________________	____________________	____________
Nombre	Firma	Fecha