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.

Neighborhood Dental

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? _____

_____

_____

_____

_____

	Yes	No
4. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other Antibiotics (Please list)	❑	❑
_____		
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	❑	❑	_____		

	Yes	No
13. Women Only:		
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. If we place your account with AAA Collections, we will be adding [24%] to the total balance to cover the cost of collections.

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 into 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