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 interested in our in-house payment program through Care Credit or Cherry Finance?

❑ Yes ❑ No

❑ Check this box if you agree to receive commercial electronic messages from Neighborhood Dental. These messages may be related to your appointment, your health care, or the products and services we provide to our patients.

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 ____________

Emergency Contact ______________________ 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#____________

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ____________

1. Have you ever been diagnosed with periodontal disease?______________________
2. Have you ever been told that you snore? ______________________
3. Do you like your smile? ____________ How would you rate your smile on a scale from 1-10? ____________
4. What changes would you make to improve your smile?______________________

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 # ______________________

Over Please...

Patient Medical History

Printed Patient Name:______________________________

Do we need to update your contact information?__________

Primary Care Physician: ______________________________ Last Exam Date: ______________

	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?__________

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	Yes	No
4. **PRE-MED** Do you require or has your physician recommended a pre-med antibiotic prior to dental treatment?	❑	❑

If yes, do you have any of the following:

- Artificial Heart Valve ❑
- Congenital Heart Defect ❑
- Infective Endocarditis ❑
- Organ Transplant ❑

OTHER:______________________________

5. 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)	❑	❑
Sulfa Drugs	❑	❑
Codeine / Narcotics	❑	❑
Acrylics	❑	❑
Food Allergies	❑	❑
Aspirin	❑	❑
Any Metals (e.g Nickel, Mercury, etc.)	❑	❑
Latex Rubber	❑	❑

OTHER (Please list): ______________________________

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6. **SLEEP**

	Yes	No
a) Have you been told/know you snore?	❑	❑
b) Do you have troubles sleeping?	❑	❑
c) Do you clench or grind your teeth?	❑	❑
d) Do you have sleep apnea?	❑	❑

	Yes	No
7. Do you use tobacco / e-cigarettes?	❑	❑
8. Do you use controlled substances?	❑	❑
9. **Are you taking any blood thinners?**	❑	❑

If Coumadin (Warfarin), most recent INR:______________

	Yes	No
10. **Are you taking any bone strengthening medications (bisphosphonates)?**	❑	❑
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 any special needs/requirements that we should be aware of in order to accommodate you better?	❑	❑

(i.e. ASD- Autism Spectrum Disorder/SPD- Sensory Processing Disorder, high anxiety, etc.)

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

	Yes	No
AIDS or HIV Infection	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Type:__________		
Cardiac Pacemaker / Defibrillator	❑	❑
Cognitive Impairment	❑	❑
Diabetes	❑	❑
Type:______		
Most Recent A1C:______		
Emphysema/COPD	❑	❑
Epilepsy	❑	❑
GERD / Acid Reflux	❑	❑
Heart Attack	❑	❑
Date: ______		
Heart Disease	❑	❑
Type: ______		
Herpes/ Cold Sores	❑	❑
Hepatitis	❑	❑
High Blood Pressure	❑	❑
Joint Replacement	❑	❑
Kidney Disease	❑	❑
Leukemia	❑	❑
Liver Disease	❑	❑
Low Blood Pressure	❑	❑
Radiation Therapy	❑	❑
Respiratory Problems	❑	❑
Seizures	❑	❑
Stroke	❑	❑
Date: ______		
Thyroid Problem	❑	❑
Tuberculosis	❑	❑

OTHER__________

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14. **WOMEN ONLY:**

	Yes	No
a) Are you pregnant or think you may be pregnant?	❑	❑
If yes, due date:______________		
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

15. **SIGNATURE REQUIRED:**

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature: ______________________________

Date: ______________

Over Please...

Acknowledgement of *Notice of Privacy Practices*

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and provider certifications.

I acknowledge that I have read and may request a copy of Neighborhood Dental's *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that Neighborhood Dental restrict how my private information is used and disclosed to carry out treatment, payment, or healthcare operations. I also understand Neighborhood Dental is not required to agree to my requested restrictions, but if in agreement, Neighborhood Dental is bound to abide by such restrictions.

Signature:____ **Date:**______________

I give my permission to discuss my dental treatment (including, but not limited to: Treatment, Scheduling, Billing, Insurance) with the following groups or individuals:____

____

Signature:____ **Date:**______________

Financial Policy

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 estimated portion of the fees is required on the day services are rendered. We accept cash, personal checks, money orders, Mastercard, Visa, Discover, American Express, Cherry, and Care Credit. If a personal check is returned for non-sufficient funds (NSF), you may be charged a third party collection fee. You will also be required to pay with either cash or credit card for any future visits.

Cherry and Care Credit are available in our office, and provide extended payment plans with prior credit approval.

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

Our Dental Savings Plan, an alternative to traditional dental insurance, is designed to save you pain, time, and money. It's a great way to get the care you need with the savings you want. Ask our team for more information today.

Dental insurance is a contract between the group/plan and the patient. The extent of coverage varies greatly between plans and sometimes even within 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.** Please note that the portion you pay on the date of your service is only an estimate, and may change depending on the insurance coverage. We will submit your insurance claim as a courtesy to you. If your insurance pays differently than our estimate, we will either refund you or the remainder will be due within 15 days of the first statement date.

In the case that you have an unpaid remaining balance after all insurance is paid, we will attempt to reach you to collect. In the event that we are unsuccessful, we may place your account with a collection agency. Upon placement, we will add a minimum fee of 24% to the total balance to cover the cost of collections fees, litigation costs, and any other additional fees that may occur.

Appointments are reserved exclusively for you. Some appointments may require a non-refundable deposit to hold your reservation. Your deposit will apply to your estimated patient portion, if completed as scheduled. The clinic requires a notice of at least one (1) full business day if the patient is unable to keep the reserved appointment time. We will attempt to contact you prior to your appointment to confirm your reservation. If an appointment is not confirmed within one business day of the appointment, the appointment may be canceled or rescheduled. **You may be charged for missed appointments or cancellations with less than 1 full business day's notice. If a patient "no-shows" or an appointment is "short-notice canceled" for three appointments, we will move you to a same-day-only scheduling list.** As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening should arise.

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 to the appointment is responsible for paying the patient portion on the day of service.

☐ I have read and understand this financial and cancelation policy.

____

Patient   Date

____

Patient/Guardian Signature   Date