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?

☐ Yes ☐ No

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 _____

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 Name: _____

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: _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. **PRE-MED** Do you require or has your physician recommended a pre-med antibiotic prior to dental treatment?	☐	☐
If yes, for what reason? _____		
5. 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
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8. **Are you taking any blood thinners?**	☐	☐
9. **Are you taking any bone strengthening medications (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
AIDS or HIV Infection	☐	☐	Joint Replacement or Implant	☐	☐
Anemia	☐	☐	Date: _____	☐	☐
Arthritis	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Leukemia	☐	☐
Cancer	☐	☐	Liver Disease	☐	☐
Type: _____			Low Blood Pressure	☐	☐
Cardiac Pacemaker	☐	☐	Valve Replacement	☐	☐
Diabetes	☐	☐	Radiation Therapy	☐	☐
Type: _____			Respiratory Problems	☐	☐
Emphysema	☐	☐	Rheumatic Fever	☐	☐
Epilepsy/Convulsions	☐	☐	**Stroke**	☐	☐
Fainting/Seizures	☐	☐	Date: _____		
Heart Attack	☐	☐	Thyroid Problem	☐	☐
Date: _____			Tuberculosis	☐	☐
Heart Disease	☐	☐	Other (please list)	☐	☐
Type: _____			_____		
Heart Murmur	☐	☐	_____		
High Blood Pressure	☐	☐			

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_____

Neighborhood Dental

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, and Care Credit. If a personal check is returned for non-sufficient funds (NSF), you may be charged a collection fee. You will also be required to pay with either cash or credit card for any future visits.

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.

Our Dental Savings Plan, an alternative to 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 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) 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 business day's notice. If a patient "no-shows" or an appointment is "force-cancelled" 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 policy.

Patient _____ Date _____

Patient/Guardian Signature _____ Date _____