THE TOOTH FIXER
Family Dental Care

Thank you for choosing The Tooth Fixer Family Dental Care! We will strive to provide our patients the best possible care. To help us meet all of your dental needs, please fill out this form completely. If you have any questions or need assistance, please feel free to ask any staff member. We will be happy to help.

Today's date _____

Patient Information

Name _____ Prefer to be called _____ DOB _____Sex _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____Work _____

Email _____

Check appropriate box: Married ( ) Single ( ) Divorced ( ) Minor ( ) Other _____

Referred to our office by: _____

Responsible Party Information

Name of Responsible Party (guardian) _____ SS# _____

Address (if different than patient) _____ City, state, Zip _____

Employer _____ Phone # _____

Responsible Party's Spouse

Name _____SS# _____ Phone # _____

Address (if different than patient) _____

City, State, Zip _____ Employer _____

Dental Insurance Information

Insurance Co _____ Insurance Co. Address _____

Subscriber Name _____

Insured DOB _____ Relationship to Patient _____Sub Id # _____

Group # _____ Employer _____

Secondary Dental Insurance Information

Insurance Co _____ Insurance Co. Address _____

Subscriber Name _____

DOB _____ Relationship to patient _____Sub Id # _____

Group # _____Employer _____

Patient Medical History *Patient name* _____

General Health: Excellent ( ) Good ( ) Fair ( ) Poor ( )

Physician _____ Office Phone _____ Date of Last Exam _____

Are you currently on any prescription or over the counter medications, vitamins, nutritional or Herbal supplements? Yes ( ) No ( )

If yes, please list medications and the purpose. _____

_____

Are you allergic to any medications? Yes ( ) No ( ) If yes, please circle or list below

Penicillin Codeine Local Anesthetics Sulfa Drugs Barbiturates Sedatives Iodine Aspirin Metals

Other (please list) _____

Please mark any that apply to you and your Medical History:

( ) Need antibiotic coverage prior to dental work?

( ) Artificial joint replacement or Implant?

( ) Under gone radiation or IV Chemotherapy?

( ) Use or have used Tobacco products?

( ) Subject to prolonged bleeding?

( ) Family History of Diabetes?

( ) Excessive thirst and /or urination?

( ) Recent unusual weight loss?

( ) Subject to fainting?

( ) Recently hospitalized or past major surgeries?

( ) Women, Currently pregnant? How far along _____

( ) Women, currently nursing?

Please circle Y or N (individually for each question).

Y N High or low Blood Pressure	Y N Heart Disease	Y N Osteoporosis	Y N Heart Attack
Y N Cardiac Pace Maker	Y N Chest Pains	Y N Rheumatic Fever	Y N Heart Murmur
Y N Swollen Ankles	Y N Artificial Heart Valve	Y N Scarlet Fever	Y N Fainting /seizures
Y N Frequently Tired	Y N Tuberculosis	Y N Asthma	Y N Anemia
Y N Glaucoma	Y N Epilepsy/Convulsions	Y N Emphysema	Y N Liver disease
Y N Leukemia	Y N Cancer (type: _____)	Y N Hemophilia	Y N Diabetes
Y N Arthritis/Rheumatism	Y N Respiratory Problems	Y N Kidney Disease	Y N Jaundice
Y N Hepatitis	Y N Mitral valve Prolapse	Y N Aids/ HIV Infection	Y N Thyroid
Y N STD	Y N Eating Disorder	Y N Stomach troubles	Y N Neck/Back Pain

Do you have any other medical or health condition(s) which are not listed? Y ( ) N ( ) If yes, please list:

_____

Signature _____ Date _____

Doctors Signature _____Date _____

Emergency Contact

Name of person _____ relationship _____

Phone # _____

Dental History *Patient name _____*

Name of Previous Dentist _____ Last Dental Visit _____

Reason for today's visit? _____

Have you ever had a serious problem associated with a previous dental treatment? Y ( ) N ( ).

If Yes, explain _____

How often do you brush? _____ How often do you floss? _____ How often do you get cleanings? _____

What dental aids do you use? Floss ( ), Toothpick ( ), Water Pick ( ), Electric Tooth Brush ( ), Other _____

Please answer yes or no:

Are you hesitant to come to the Dentist?	Yes ( ) No ( )	Do you snore or have trouble sleeping	Yes ( ) No ( )
Do your gums bleed during brushing or flossing?	Yes ( ) No ( )	Would you like to have whiter and brighter teeth?	Yes ( ) No ( )
Do you have a bad taste or odor in your mouth?	Yes ( ) No ( )	Do you have missing teeth that you want replaced?	Yes ( ) No ( )
Do have dental fillings that you don't like?	Yes ( ) No ( )	Do you have loose dentures or partials?	Yes ( ) No ( )
Do you believe in the benefits of fluoride?	Yes ( ) No ( )	Are you wearing away your teeth (grinding)?	Yes ( ) No ( )

What do you not like about your smile?

_____

_____

What can we do to make your smile better?

_____

Consent of treatment

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 the incorrect information can be dangerous to my health. I hereby authorize The Tooth Fixer Family dental to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment, such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

***Responsibility of payment*:** In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection sums due and unpaid for the work herein set forth.

Signature _____ Date _____

Children or Minors

Because (name of child) _____ is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their treatment.

Signature _____ Date _____

The Tooth Fixer Family Dental Care FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to offering you quality preventive care and treatment. Please understand that payment of your bill is considered part of your care. The following is a statement of our Financial Policy, which we require you to read and sign.

Patients without Dental Insurance Coverage: Full Payment is due on the day of service. We accept cash, checks, and credit cards. Financing is available with approved application.

Regarding Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We file dental insurance as a courtesy to our patients. In order for us to bill your insurance company and obtain payment from them, we must have all of your insurance information on file. Your insurance plan may pay for some procedures in full. However, most treatment will only be partially covered by insurance. We cannot guarantee payment of insurance for any procedure. Any estimate given for fee of treatment or co-pay is strictly an estimate. You can assist us in making accurate estimates by being familiar with your plan provisions and updating your insurance information any time changes are made to your policy. We will file your claim in a timely manner and as an extra courtesy will follow up on any unpaid claims 30 days outstanding from the filed date. **If your insurance has not paid your claim within 60 days, the claim is deleted from our files and the balance due becomes your responsibility to pay.** You can then seek reimbursement from your insurance company. **Your co-pay (a percentage paid by the patient) and any applicable deductible are due in full on the day of service. Any remaining balance due after a claim has been processed, will be your responsibility to pay.** Secondary Insurance coverage will only be filed if the primary carrier's payments come directly to us. **Upon signing this statement, you authorize all insurance payments to be paid directly to The Tooth Fixer Family Dental Care.**

Usual and customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment of any outstanding balance once your insurance claim has been paid regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients: The adult accompanying a minor must agree to be the "responsible party" and must be prepared to pay any balance (co-pay) due at time of service. For all minors, written consent from the legal guardian for treatment must be made prior to treatment and prior to payment arrangements must be made. If more than one party is legally responsible for payment on a child's account the adult who accompanies the minor to the appointment will need to arrange for full payments or co-pays to be made at the time of the service. Appointment information, recall notices and billing statements will be sent to the same address.

Past due account balances over 90 days from the Date of Service will be subject to a 1.5% monthly late charge.

There will be an additional $40.00 (forty) charge for each returned check or NSF check(s).

I have read the Financial Policy. I understand and agree to it. I understand that should my account be turn over to collections, I will be responsible for any and all fees associated with the collection process.

Name of patient or responsible party: _____

Signature _____ **Date** _____

The Tooth Fixer Family Dental Care

Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it. Morning appointments may be best for more complicated procedures.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will be understanding of the situation. At some point, they may need the same courtesy too!

Like many offices, this office does call to confirm your appointment. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. **There will be a charge of <u>$50.00 per 1 hour of scheduled time</u> for a broken appointment or cancellation with less than 24 hours' notice prior to your appointment.**

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

I have read and understand The Tooth Fixer Family Dental Care Cancellation and No-show Policy.

Patient's name (Print) _____

Signature _____

Date _____

The Tooth Fixer Family Dental Care

Acknowledgement of Receipt of Notice of Privacy policies

I have received a copy of the Notice of Privacy Practices of The Tooth Fixer Family Dental Care. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent Form.

Patients Name (print)_____

Patient/Guardian Signature_____ Date_____

Please check your preferred means of communication:

Contact me at my home phone number _____

MAY WE LEAVE A MESSAGE ON YOUR HOME PHONE? YES____ NO____

Contact me on my cell Phone number _____

MAY WE LEAVE A MESSAGE ON YOUR CELL PHONE? YES____ NO____

It's okay to send a text message to remind me of any appointments? YES____ NO____

You may send me an e-mail @_____

Other _____

Please list authorized persons with whom we may discuss your Protected Health information (PHI) in addition to custodial parents and legal guardians:

1. **Name:**_____**Date** (Added/Removed)**:**_____
2. **Name:**_____**Date** (Added/Removed)**:**_____
3. **Name:**_____**Date** (Added/Removed)**:**_____
4. **Name:**_____**Date** (Added/Removed)**:**_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

Individual refused to sign_____

Communication barrier prevented us from obtaining the acknowledgement_____

An emergency situation prevented us from obtaining it _____

Other _____ Specify: _____

How did you hear about us?

☐ Referred by a friend or family member:_____
(Name)

☐ Referred by a Doctor/Specialist _____
(Name)

☐ Internet _____
(Google, Yelp, On-line reviews, Facebook, Etc.)

☐ Your insurance directory _____

☐ Newspaper _____
(Name of paper)

☐ Our Sign _____

☐ Other _____
(Specify)