Patient Information

Name_____ Preferred Name_____
Address_____ SS#_____
City_____ State_____ Zip_____ Home Phone_____
Cell Phone_____ Email _____
Sex(circle one) M/F Birthdate_____ Single/Married/Widowed/Separated/Divorced
Patient employed by_____ Occupation_____
Business Address_____ Business Phone_____
Business Email_____
How did you hear about Byron Center Family Dental?_____
Notify in case of emergency_____ Home phone_____
Cell Phone_____ Business phone_____
Email_____

Primary Insurance

Person responsible for account_____
Relation to patient_____ Birthdate_____ SS#_____
Address (if different from patient)_____ Home phone_____
City_____ State_____ Zip_____
Cell Phone_____ Email_____
Person responsible employed by_____ Occupation_____
Business Address_____ Business phone_____
Insurance Company_____ Phone_____
Subscriber #_____ Group #_____
Name of other dependents under this plan_____

Additional Insurance

Is patient covered by additional insurance? Yes No (circle one)
Subscriber Name_____ Relation to patient_____ Birthdate_____
Address(if different from patient)_____ SS#_____
City_____ State_____ Zip_____
Cell phone_____ Email_____
Subscriber employed by_____ Business Phone_____
Insurance Company_____ Phone_____
Subscriber #_____ Group #_____
Name of other dependents under this plan_____

Previous Dentist

Who is your previous dentist?_____
Dentist's Address_____ Phone_____
City_____ State_____ Zip_____
When was your last dental examination?_____
Did you have any difficulties with your previous dentist?_____
_____
What could your previous dentist have done to make your experience better?
_____

Medical & Dental History Form

Name _____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ○ Yes ○ No

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name, address and phone #: _____

_____

Please mark any of the following to indicate YES in response to the question:

- ○ Have you ever had complications following dental treatment?
- ○ Are you currently under the care of a physician due to a specific condition?
- ○ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ○ Are you currently taking any prescription or non-prescription medications?
- ○ Do you use tobacco (smoking or chewing)?
- ○ Do you require the use of corrective lenses (contacts or glasses)?
- ○ Do you have any other conditions, diseases, etc. not listed above that should be aware of?

If any of the previous questions are marked, please explain: _____

_____

WOMEN ONLY: Are you pregnant? ○ Yes ○ No

If yes, when is the due date? _____

Please indicate if you have experienced any of the following:

- ○ Allergies
- ○ Artificial Joints
- ○ Cancer
- ○ Dizziness
- ○ Fainting
- ○ Hay Fever
- ○ Heart Murmur
- ○ HIV
- ○ Liver Disease
- ○ Pregnancy
- ○ Respiratory Problems
- ○ Sinus Problems
- ○ Tuberculosis
- ○ Venereal Disease
- ○ Other

- ○ Anemia
- ○ Asthma
- ○ Codeine Allergy
- ○ Epilepsy
- ○ Glaucoma
- ○ Head Injuries
- ○ Hepatitis
- ○ Jaundice
- ○ Mental Disorders
- ○ Pacemaker
- ○ Pre-Med
- ○ Rheumatic Fever
- ○ Stomach Problems
- ○ Tumors

- ○ Arthritis
- ○ Blood Disease
- ○ Diabetes
- ○ Excessive Bleeding
- ○ Growths
- ○ Heart Disease
- ○ High Blood Pressure
- ○ Kidney Disease
- ○ Nervous Disorders
- ○ Penicillin Allergy
- ○ Radiation Treatment
- ○ Rheumatism
- ○ Stroke
- ○ Ulcers

Do you have any other health issues or allergies?

_____

_____

What is the reason for your dental visit today?

_____

_____

How often do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How often do you floss your teeth?

○ 1 (+) a day ○ 2-6 Weekly ○ 1-6 Monthly ○ Seldom ○ Never

Please mark any of the following to indicate YES in response to the question:

- ○ Do your gums bleed when you brush or floss?
- ○ Do your teeth experience sensitivity to cold or hot temperatures?
- ○ Are any of your teeth currently causing you pain?
- ○ Do you currently have any dental implants, dentures or partials?

If any of the previous questions are marked, please explain:

_____

_____

If you could change anything about your mouth, teeth or smile, what would it be?

_____

_____

○ ***To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.***

X _____

Consent for Treatment:

I hearby certify that I have read and understand the information provided and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

Financial Policy:

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of my department(s), if any. Byron Center Family Dental realizes that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an induvidual's medical and psychological care. We are always available to answer your questions or assist you in any way we can. To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Optional Payment Terms

Full Payment on Date of Service - Cash discount. We offer a 5% discount for all treatment that is paid in full (cash or check) on the day of your visit for self-pay accounts only. Seniors (62+ years) receive a 10% discount with cash or check.

Major Service- Two-Payment Option- We offer a two-payment option for crowns, bridge, implant and denture treatment. We ask that you pay one-half the day of the first appointment and the remaining half the day it is completed. Both payments are expected prior to completion or we will reschedule.

Credit Card Payment Option- We allow credit card payment with a signed agreement form and established payment history with one-third payment due at the first appointment, one-third payment due 30 days later, and the remaining one-third payment due 60 days later after the initial appointment. Our office personnel will charge these payments to your credit card on the due dates.

Term Loan- By arrangement with care credit, we offer our patients, upon approval, an interest-free loan (up to 18months) with no down payment, no annual fee and no prepayment penalty. Please ask us for more information.

Payments are expected at the time the services are rendered. We accept cash, checks, debit card, Visa, Discover, and Master Card. There is a $35.00 charge for any checks returned for insufficient funds.

Missed/Broken Appointment Policy:

The missed appointment policy in our office tries very hard to maintain our schedule so that all our patients can be treated promptly. We do understand that with everyone's busy schedule that things do come up periodically, and you may be unable to keep your appointment. We require a 48-hour/2 business days notice if you are unable to keep your appointment. There will be a $75.00 fee charged for the first missed appointment and you will be rescheduled. If a second missed appointment happens, we will ask that you prepay for your treatment before we can reschedule any further appointments. If a third missed appointment happens, you will be dismissed as a patient from our office.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).

Obtaining payment from third-party payers (e.g. my insurance company)

The day-to-day healthcare operations of this practice. This may include, but not limited to, postcards, newsletters, phone calls, voicemail, and emails necessary for my continued dental health.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do not agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke is not affected.

Signed this _____ day of _____, 20 _____

Printed Patient Name: _____

Relationship to Patient: _____

Signature: _____

General Photography Release

I hearby authorize Byron Center Family Dental to publish photographs taken of me or my children for use in the Byron Center Family Dental print, online, and video-based marketing materials, as well as other publications.

I hearby release and hold harmless Byron Center Family Dental from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other publications. I acknowledge and agree that publication or said photos confers no rights of ownership or royalties whatsoever.

I hearby release Byron Center Family Dental, it's contractors, it's employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization

Printed Name: _____

Signature: _____ Date: _____

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Authorization

Printed Name: _____

Signature: _____ Date: _____