Delicate DENTAL

Welcome to Delicate Dental

Date ____/____/____

PATIENT INFORMATION

Patient Name:_____

Social Sec. #:_____ Date of birth:____/____/____

Email: _____ Cell #:_____

Street Address:_____

City/State/Zip_____ Phone:_____

Other Phone:_____ E-Mail: _____

Circle One: M / F Family Status: Married Single Child Other

Employer:_____

Employer Address:_____

City/State/Zip_____ Phone:_____

Emergency Contact Name:_____

Phone:_____ Date of Last Visit:_____

Were you referred to us from another dental office?
Dentist's name:_____

RESPONSIBLE PARTY INFORMATION

Name:_____

Social Sec. #:_____ Date of birth:____/____/____

Street Address:_____

City/State/Zip_____ Phone:_____

Other Phone:_____ E-Mail: _____

Circle One: M / F Family Status: Married Single Child Other

Employer:_____

Employer Address:_____

City/State/Zip_____ Phone:_____

INSURANCE INFORMATION

Primary Insurance _____

Name of Insured:_____

Date of Birth: ____/____/____

Social Sec./Member#:_____ Group #:_____

Secondary Insurance _____

Name of Insured:_____

Date of Birth: ____/____/____

Social Sec./Member#:_____ Group #:_____

Relation to patient: _____

I agree that I read, write and comprehend in English. _____
❑ ***Yes*** ❑ ***No*** *Initials*

PLEASE DO NOT WRITE IN THIS AREA - OFFICE USE ONLY

_____
Doctor's Initials

I agree there are no changes on my health history.

_____ _____
Name *Date*

Answer all questions by circling Yes (Y) or No (N) All responses are kept confidential.

1. Are you in good health?.....Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last physical exam_____
4. Are you now under a physician's care for a particular problem?.....Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe.....Y N
   _____
   _____
6. Height _____ Weight _____
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   B. Congenital Heart Disease?.....Y N
   C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, Mitral Valve Prolapse).....Y N
   D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?.....Y N
   E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder?.....Y N
   F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
   G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   H. Kidney Disease?.....Y N
   I. Diabetes?.....Y N
   J. Thyroid Disease (Goiter)?.....Y N
   K. Arthritis?.....Y N
   L. Stomach Ulcers or Colitis?.....Y N
   M. Glaucoma?.....Y N
   N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?.....Y N
   O. Radiation (X-ray) treatment for Cancer?.....Y N
   P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N
   R. Any disease, drug or transplant operation that has depressed your immune system?.....Y N
   S. HIV, AIDS or ARC?.....Y N
8. ARE YOU USING ANY OF THE FOLLOWING:
   A. Antibiotics?.....Y N
   B. Anticoagulants (Blood Thinners)?.....Y N

   PLEASE LIST ALL YOUR MEDICATIONS: .....
   .....
   .....
   .....
   .....
9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   A. Local Anesthesia (Novocain, etc.)?.....Y N
   B. Penicillin or other antibiotics?.....Y N
   C. Sedatives, Barbituates?.....Y N
   D. Aspirin or Ibuprofen?.....Y N
   E. Codeine or other pain killers?.....Y N
   F. Latex or Rubber products?.....Y N
   G. Other allergies or reactions? Please, List.....Y N
   _____
   _____
10. Do you smoke or chew Tobacco?.....Y N
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
12. Any serious problems with previous dental treatment?.....Y N
13. Have you or an immediate family member had any problem associated with anesthesia?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
15. Do you wish to talk to the doctor privately about anything?.....Y N
16. FOR WOMEN ONLY
    A. Are you Pregnant, or is there any chance you might be Pregnant?...Y N
    B. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

X _____

DELICATE DENTAL
FINANCIAL INFORMATION

Thank you for choosing Delicate Dental.It is our goal to provide the finest care possible,
This information will explain how we well help you take care of your financial needs.

WE HAVE MANY PAYMENT OPTIONS AVAILABLE

MasterCard, Visa, Discover & American Express
Personal Checks, Cash, ATM/Debit
Payment plans are available. Please ask your treatment coordinator for an application.

INSURANCE: As a courtesy, we will bill your insurance company for covered charges. In order to bill your insurance you will need to provide us with the necessary, accurate and complete information. Remember that your insurance policy is a contract between you and your insurance company and you are responsible for all charges incurred. We expect insurance payment within 45 days from the date of service. If your insurance has not paid and the account becomes 60 days old, the account may become a cash account and may be due and payable at that time.

I hereby guarantee payment of all charges incurred for the account of the above mentioned. I realize that insurance **may not** cover the amount charged and that I will be responsible for the balance left after insurance. I understand that balances not paid in a timely manner are subject to additional charges and or collection procedures. **If there is no insurance coverage available, I understand that I am responsible for all charges incurred, at the time of service.**
Signature_____ Date_____

We have a strict cancellation policy. There will be a charge of up to $200 for any cancellations not given within 48 hours**.**
Signature_____ Date_____

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Release of Information and Assignment of Benefits

I authorize the release of any dental or medical information necessary to the process claims, and I authorize payment of benefits to Delicate Dental for services rendered. I authorize the use of my signature for processing of benefits.

Signature_____ Date_____

Privacy Policy

Our office policies meet the requirements of the Federal Government's ***Health Portability and Accountability Act***. It is for this reason that we can not respond to any patients remarks that may be posted via the world wide web and/or all major search engines. If you post any comments or remarks about our company, we will pursue legal action to have those postings removed. If you should decide to breach this contract, it will result in unwanted legal fees at your expense. Our office will send patient surveys to every patient who has an email account in which you may post comments and reviews on this electronic survey. In accordance with Federal law, beginning April 2003, a copy of our **"Notice of Privacy Practices"** is available at check-in. Please take it with you and review at your convenience.

The office's "Notice of Privacy Practices" have been made available and I have read the above disclaimer and agree to all terms.

Signature_____ Date_____

May the Drs / Staff text you for follow-up regarding your care?_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our "Notice of Privacy Practices," but acknowledgement could not be obtained because: ___ Individual refused to sign ___ Communications barriers ___ Emergency situation
___ Other _____

_____

Limited Warranty

People always ask us, "How long should this last?" In our office, we strive for perfection and satisfaction, which is why we are happy to provide you this warranty, something few other offices offer. Let us remember in today's technology almost everything we have learned is on the preventive side. Instead of going to the dentist every few years for "Drill, Fill and Bill," let's try preventative dentistry. You can prevent most or all disease if you spend 4 minutes in the morning and 4 minutes in the evening brushing, flossing and doing any other special treatments your dentist and hygienist have recommended and have your dentist or hygienist professionally clean your teeth, check for decay, apply a fluoride treatment, or apply sealants. We strive to make our patients happy with their smile, that is why, if you keep your 6 month check up appointments and all regular scheduled appointments we will place a five year warranty on all work completed (Root Canals Not Included) Our warranties must be null and void if we don't see you for your regular 6 month check-ups. With 6 month check-ups your teeth and gums are winners!

_____ _____
Signature of Patient/Guardian Date