DENTAL FAITH
AESTHETIC & FAMILY DENTISTRY

Date_____

Whom may we thank for referring you? _____

PATIENT INFORMATION

Patient Name _____ Preferred Name _____
Address _____ City/State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____
Sex F/M Age _____ Birthdate _____/_____/_____ Marital Status _____ SSN _____
Employer _____ Occupation _____
Employer Address _____ Employer Phone _____
Spouse Name _____ Phone #_____

GUARDIAN INFORMATION (if applicable)

Name _____
Address _____ City/State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____
Birthdate _____ SSN _____
Employer _____ Occupation _____
Employer Address _____ Employer Phone _____

Who is responsible for this account? _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company _____
Name of Primary Policy Holder _____ Birthdate _____
SSN _____ Relationship to the patient _____
Policy # _____ Group # _____
Union or Local # _____ Anniversary Date of Policy _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

EMERGENCY INFORMATION

Who may we contact in case of an emergency? _____ Relationship _____
Home Phone # _____ Cell # _____ Work phone # _____

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Patient Name _____

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ Phone # _____ City/State _____
Date of Last Dental Visit _____ Date of last dental X-Rays _____
Date of Last Dental Cleaning _____ Regular cleaning _____ Deep Cleaning _____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? Manual Toothbrush _____ Soft _____ Medium _____Hard _____
Toothpick_____ Fluoride Rinse_____ Electric Toothbrush _____ Other_____
Have you received any formal oral hygiene instruction? Y/N How long ago? _____
Do you like your smile? Y/N
How do you feel about the appearance of your teeth? _____
What do you wish could be changed? _____

Please circle YES or NO to indicate if you have had or currently have any of the following:

Cold Sores or growths in mouth	Y N	Sensitivity when biting	Y N	Pain around ear (R) (L)	Y N
Sore or Bleeding gums	Y N	Sensitivity with sweets	Y N	Change/Shift in your bite	Y N
Blisters on lips or mouth	Y N	Sensitivity to cold	Y N	Experience pain in jaw joint	Y N
Burning sensation on tongue	Y N	Sensitivity to hot	Y N	Grinding teeth	Y N
Swollen Gums	Y N	Hold foreign objects with your teeth	Y N	Clenching teeth	Y N
Dry Mouth	Y N	Chew on one side of mouth	Y N	Chewing tobacco	Y N
Bad Breath	Y N	Fingernail biting	Y N	Smoke Cigarette, pipe, cigar	Y N
Mouth breathing	Y N	Lip or cheek biting	Y N	Difficulty with any dental work	Y N
Loose teeth	Y N	Clicking or Popping of the jaw (R) (L)	Y N	Problems getting numb	Y N
Broken teeth/ filling(s)	Y N	Difficult in opening or closing mouth	Y N	Wear a bite plate or mouthguard	Y N
		Tired jaws, especially in the morning	Y N	Excessive stress or pressure	Y N

A serious injury to the mouth or head Y N Please describe including the cause _____
Food collection between teeth Y N Please indicate location _____
Extractions Y N
Endodontic Treatment (Root Canals) Y N
Periodontal Treatment Y N If yes please indicate:

- Osseous Surgery Date _____
- Tissue Gingival Grafts Date _____
- Tissue Management (Scaling, Curettage) Date _____

Do you feel nervous about having dental treatment? Y N
Have you ever had an upsetting dental experience? Y N _____
Is there anything else about having dental treatment that you would like us to know? Y N
If yes to any of the above, please describe _____
_____

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MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____
Address _____ City _____ State _____ Zip Code _____
Have you been under the care of a medical doctor during the past two years?_____ Y N
If yes, for what? _____

Please check yes or no to indicate if you have had any of the following:

AIDS / HIV positive	Y N	Emphysema	Y N	Pacemaker	Y N
Alcoholism/Drug Abuse	Y N	Epilepsy or Seizures	Y N	Psychological Problems	Y N
Anemia	Y N	Fainting or Dizzy Spells	Y N	Psychiatric Care	Y N
Arthritis, Rheumatism	Y N	Glaucoma	Y N	Radiation Treatment	Y N
Artificial Heart Valves	Y N	HPV (Human Papilloma Virus)	Y N	Respiratory Disease	Y N
Asthma	Y N	Headaches	Y N	Rheumatic Fever	Y N
Back Problems	Y N	Heart Murmur	Y N	Scarlet Fever	Y N
Bleeding Abnormally	Y N	Heart Problems	Y N	Shortness of Breath	Y N
Blood Disease	Y N	Hemophilia	Y N	Sickle Cell Disease	Y N
Blood Transfusion	Y N	Hepatitis Type _____	Y N	Sinus Problems	Y N
Cancer Where_____	Y N	Herpes	Y N	Skin Rash	Y N
Chemical Dependency	Y N	High Blood Pressure	Y N	Stomach Disorder	Y N
Chemotherapy	Y N	High Cholesterol	Y N	Stroke	Y N
Circulatory Problems	Y N	Jaundice	Y N	Swelling of Feet or Ankles	Y N
Congenital Heart	Y N	Jaw Pain	Y N	Swollen Neck Glands	Y N
Contact Lenses	Y N	Joint Replacement When _____	Y N	Thyroid Problems	Y N
Cortisone Treatments	Y N	Kidney Disease	Y N	Tonsillitis	Y N
Cough, Persistent/Bloody	Y N	Liver Disease	Y N	Tuberculosis	Y N
COVID-19 When _____	Y N	Low Blood Pressure	Y N	Tumor or Growth on Head or Neck	Y N
Cysts/Tumors Where_____	Y N	Mitral Valve Prolapse	Y N	Ulcer	Y N
Diabetes A1C_____	Y N	Neurological Disorders	Y N	Venereal Disease	Y N
Diet (Restricted / Special)	Y N	Nervous or Anxiety Problems	Y N	Weight Loss or Gain, Unexplained	Y N

Allergies [ ] NONE [ ] Amoxicillin [ ] Aspirin [ ] Barbiturates [ ] Codeine [ ] Epinephrine [ ] Erythromycin [ ] Keflex
[ ] Iodine [ ] Latex [ ] Lortab [ ] Penicillin [ ] Sulfite [ ] Sulfa [ ] Tetracycline [ ] Other _____

List medications currently taking (name and dosage) _____

_____

Do you have or have you had any disease, condition or problem not listed above? Y N
If yes, please explain: _____
Do you need to take any antibiotics (pre-medicate) before any dental appointment? Y N Why? _____
Are you taking blood thinners (Anticoagulants)? Y N Why? _____
Have you been in the hospital or had a serious illness within the past five years? Y N When? _____
If yes, Please explain: _____
Women: Are you pregnant? Y N Due date _____ Are you nursing? Y N Do you take Birth Control Pills? Y N

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Parent / Guardian Signature_____ Date _____
Doctor Signature _____ Date _____

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Patient Name _____

CONSENT FOR SERVICES, APPOINTMENT AND PAYMENT POLICIES

Dental Faith is happy to take care of your dental needs. Please help us by following our appointment and payment policies.

Broken or cancelled appointments
If you need to cancel an appointment, please notify us **at least 48 hours in advance** for Tuesday through Saturday appointments and no later than 10:00 am Friday for Monday appointments. If we cannot confirm the appointment with you, it may be given to someone else.
We charge $50.00 for each canceled or broken appointment if you do not give us the required advance notice. Please notify us if an emergency makes it impossible for you to give 48 hours notice so we can discuss this with you.
Please DO NOT cancel an appointment with a voicemail message or text. Instead, please talk to us during office hours to avoid confusion. Our office hours are Monday through Friday from 9:00 am to 6:00 pm and Saturday from 8:30 am to 3:30 pm.

Please arrive 10 minutes prior to your appointment. If you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless we can still accommodate you.

Office Surveillance
Please be advised that Dental Faith is equipped with a visual and audio surveillance system throughout the clinic for your safety and ours. For your privacy, the surveillance system is not shared with any external sources and falls within HIPPA regulations regarding recordings.
Payment is due at the time of treatment
Payment for treatment is due in full at the time of treatment, unless you have made other payment arrangements with us. If we are filing an insurance claim for you, please read the next section for an explanation of payment arrangements.
Insurance claims
If we file an insurance claim for you, you will need to pay us at the time of treatment the expected estimated insurance deductible and any estimated amount that we expect insurance will not cover.
We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits.
Returned checks
Please take every precaution to avoid giving us a bad check. It is time consuming for our staff to deal with returned checks and this takes away from the more important job of providing dental services. For this reason, we charge $30.00 for any check that is returned to us without payment. Also, if you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.
Copy and/or Transfer of your X-Rays
You have the right to copy your X-Rays, by filling out the release authorization form, records will be sent within 2-3 business days of the receipt of your written request. For providing an electronic or paper copy of your X-Rays, we will charge you an administrative fee $25.00 in responding to your request.
Interest on late payments
Please pay your charges on time. We rely on prompt payment from our patients and their insurance companies. We will charge your account interest at the rate of 1.5% per month (18% annually) for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.
Collection costs
We will charge your account for our collection costs if we refer your account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorneys' fees and expenses and court costs. For a referred account that is collected prior to the start of a collection lawsuit, we will add 43% to the principal amount due so that the office will be left with the full principal amount after deducting the collection agency's commission from the amount collected.
Minors in the office
Minors must always be accompanied by an adult. The adult accompanying a minor will be responsible for payment of services on their appointment. If parent is giving authorization for a Caregiver, the permission form needs to be completed prior to their visit.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.
I agree to the above policies and charges.

Patient's Name _____

Patient /Parent /Guardian Signature _____ Date _____

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient name: _____

Birthdate: _____/_____/_____

I have read a copy of the Notice of Privacy Practices for Dental Faith. I understand that I am entitled to receive a paper copy of the Notice if I ask for it.

X _____ Date signed:_____
Signature of patient or personal representative

If applicable:
Patient's Representative's name: _____Phone: _____
Representative's relationship to patient: _____
Representative's address: _____

I authorize the following individuals to receive information about my appointments, treatment and/or account:

_____	_____	_____
Print name	Relationship	Phone #
_____	_____	_____
Print name	Relationship	Phone #

PHARMACY INFORMATION:

NAME: _____ **PHONE #**: _____

ADDRESS: _____

For office use only:

Please complete the following only if the acknowledgment section above has not been signed by the patient or the patient's personal representative; We made a good faith effort to obtain a written Acknowledgment of Receipt of Notice of Privacy Practices, but an acknowledgment could not be obtained because *(please check one or more as appropriate)*:

_____ The patient or the patient's personal representative refused to sign.
_____ A communication barrier prevented us from obtaining an acknowledgment.
_____ An emergency situation prevented us from obtaining an acknowledgment.
_____ Other (please explain) _____

Completed by: _____ Position: _____

Staff member's initials: _____ Date completed: _____