Dental Horizons

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Welcome to our Practice

Whom may we thank for referring you to our practice? *

_____

_____

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Primary Dental Insurance:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Medical History

DO YOU HAVE ANY ALLERGIES?

☐ NONE ☐ Allergies ☐ Aspirin ☐ Codeine ☐ Erythro ☐ Hay Fever ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Other

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ Acid Reflux	☐ Anemia	☐ Anxiety	☐ Arthritis
☐ Artificial Bones	☐ Artificial Joints	☐ Artificial Valve	☐ Asthma
☐ Auto-Immune Disorder	☐ Bacterial Endocardit	☐ Blood Disease	☐ Cancer
☐ Chest Pain	☐ Congenital Heart Def	☐ Currently Pregnant	☐ Diabetes
☐ Dizziness/Fainting	☐ Drug Use	☐ Excessive Bleeding	☐ Frequent Headaches
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Heart Surgery
☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Nervous Disorders	☐ Osteoporosis
☐ Pacemaker	☐ Psychiatric Disorder	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Seizures	☐ Sinus Problems
☐ Sleep Apnea	☐ STI(Transmitted Inf)	☐ Stomach Problems	☐ Stroke
☐ Thyroid Disorder	☐ Tobacco Use	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Venereal Disease		

☐ Ever been hospitalized (illness or injury)
☐ Taking medication for weight control (ie fen-phen)
☐ Subject to frequent headaches
☐ FEMALE: Taking birth control pills
☐ Presently being treated for any other illnesses
☐ Taking dietary supplements
☐ A smoker or smoked previously
☐ FEMALE: Pregnant

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

Do you take antibiotic premedication for your dental visits? YES / NO If yes, please explain. _____

List all medications, supplements, and/or vitamins taken within the last two years:

_____

_____

What is your estimate of your general health? _____

Name of physician and their specialty & Date of most recent exam:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

☐ ***By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

_____

_____

Date of most recent dental exam: _____

Date of most recent dental x-rays: _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint
☐ You have any problems chewing
☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
☐ Your teeth crowding or developing spaces
☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
☐ You clench you teeth in the daytime or make them sore
☐ You have problems with sleep or wake up with an awareness of your teeth
☐ You wear or have worn a bite appliance

Tooth structure, Check all that apply:

- ☐ Cavities within past 3 years
- ☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- ☐ You notice or have holes (i.e. pitting, craters) on the biting surface of your teeth
- ☐ Any teeth sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth
- ☐ Any teeth with grooves, notches, chips, a cracked filling or pain
- ☐ Food gets caught between any teeth

Gum and Bone, Check all that apply:

- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ History of periodontal disease in your family
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- ☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

Thank you for choosing us as your dental health care provider!

We believe that all patients deserve the very best dental care we can provide. Following this belief, we strive to partner with our patients to educate them about their oral health, make recommendations based on the best personalized care options, and to make a plan for maintaining a healthy smile!

FINANCICAL POLICY

Payment is expected at time of service. As a condition of treatment by this office, any special financial arrangements must be made in advance. In the event that their is applicable insurance, the practice requires that patients pay for all of their portion of the costs incurred for their care at the time of service. Emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

There is a billing fee of 1.5% monthly (18% annually) or a minimum $10 billing charge per billing cycle for all patient balances that require a billling statement. We will waive this fee one time for any balances that you owe after your insurance has paid their portion and there will be no interest charged on the initial statement sent to notify you of your remaining balance due.

Any accounts 60 days or more past due will be turned over for collection.

There is a $30 fee for Returned Checks.

☐ ***By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

INSURANCE POLICY

Patients must present all documentation of coverage (insured info, insurance cards, policy/benefit statements, etc.) to our Front Office at the time of services in order for any insurance benefits to be applied. Failure to provide the necessary information to process your claim through our electronic submission platform may result in our inability to submit your claim. WE SUBMIT ONLY ELECTRONIC CLAIMS, NO PAPER! If we are not able to submit claims in our approved format then payment will immediately become due.

Patients are responsible for being aware of their policy benefits and limits, as it is your policy. Our Front Office will do their best to confirm these benefits and ESTIMATE costs but the insurance companies will never GUARANTEE their payment based on these estimates. Ultimately all fees for services are the responsibility of the patient.

As a condition of our agreements with insurances, Dental Horizons must collect all estimated co-payments, deductibles, and the fees for any services not covered by your insurance plan at the time the service.

If there is any balance after your insurance pays their portion, or if your insurance company does not respond with payment in a timely fashion, (within 45 days), then the patient/parent is responsible for all balances.

NO SHOW, SHORT NOTICE CANCELLATION AND SHORT NOTICE RESCHEDULE POLICY

Because we work on an appointment basis and reserve providers to provide patient care for those appointments, we require at least 24 HOURS ADVANCE NOTICE for rescheduling or cancelling appointments. Failure to provide notification may result in a ($65) charge for the missed appointment.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Signature _____ **Date** _____

Response Date: _____