

# W E L C O M E

## PATIENT INFORMATION

Date \_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_  
Patient \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_  
Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
Occupation \_\_\_\_\_  
Patient Employer/School \_\_\_\_\_  
Employer/School Address \_\_\_\_\_  
Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_  
SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## PHONE NUMBERS

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

# HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses?  Yes  No

## Women:

Are you pregnant?  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

## ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	

## UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the *Health Insurance Portability & Accountability Act of 1996 (HIPAA)*, I have certain rights to privacy regarding my protected health information (**PHI**). I understand that this information can and will be used to:

- conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- obtain payment from third-party payers;
- and to conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

**Patient Name:** \_\_\_\_\_

**Relationship to Patient:** (Circle one)    **SELF**    **PARENT**    **GUARDIAN**    **OTHER**

**Signature of Responsible Party:** \_\_\_\_\_

### FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was not able to do so as documented below:

<u>Date</u>	<u>Initials</u>	<u>Reason / Circumstances</u>

## Acknowledgement and Consent

By signing below, I acknowledge that I have read, understand and agree to the following:

### Consent of Treatment

I, the undersigned, do hereby authorize Dr. Timothy Case and staff to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Case to make a thorough diagnosis of the patient's dental needs. I also understand that the use of anesthetic agents embodies a certain risk.

\_\_\_\_\_  
**Signed**

\_\_\_\_\_  
**Date**

I understand that if I do not keep my Account current that a 2.6% Finance Charge will be applied to my Account when it reaches sixty (60) days old, regardless of Insurance payments.

\_\_\_\_\_  
**Signed**

\_\_\_\_\_  
**Date**

I understand that if I do not make a payment within twenty (20) days of my billing date, a \$45.00 Late Payment Charge will be applied to my Account. This will take place every thirty (30) days that we do not receive a payment. Any Account with three (3) consecutive Late Payment Charges will be sent to a Collection Agency. I agree to pay Collections costs and reasonable attorney fees incurred in attempting to collect on this Account.

\_\_\_\_\_  
**Signed**

\_\_\_\_\_  
**Date**

**Name** \_\_\_\_\_

**Current Address** \_\_\_\_\_  
\_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

If you do not have your estimated portion at the time of service, we will have to reschedule your appointment. Also, if you do not have proof of your insurance, you will be responsible for all charges rendered.

Initials \_\_\_\_\_ Date \_\_\_\_\_

There will be a mandatory \$5.00 Infection Control charge for all patients at each visit. This charge goes towards all items needed for ensuring that all equipment / instruments are properly sterilized. We want to serve you in a clean and safe environment every time you visit. This charge gives us that opportunity.

Initials \_\_\_\_\_ Date \_\_\_\_\_

I understand that verifying my insurance is a courtesy that Dr. Case provides. It is legally my responsibility to know and understand my dental benefits.

Initials \_\_\_\_\_ Date \_\_\_\_\_

I understand that anything given to me on a treatment plan is an ESTIMATE. I understand that my treatment is subject to change, resulting in a possible higher cost and additional appointments than originally outlined.

Initials \_\_\_\_\_ Date \_\_\_\_\_

R&C Rates (Reasonable and Customary Rates): Our practice is committed to providing the best treatment possible to our patients, and we charge what is reasonable and customary in the St. Louis area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of RCR.

Initials \_\_\_\_\_ Date \_\_\_\_\_

I understand that my Insurance Company, for whatever reason, may not pay for services rendered. I understand that ultimately, I am financially responsible for any services rendered. If my insurance does not pay for a claim within three (3) months of the date of service, I am to pay the balance of that claim. It will then be my responsibility to get reimbursement from my insurance company.

Initials \_\_\_\_\_ Date \_\_\_\_\_

I understand that there is a \$45-per hour-scheduled Missed Appointment charge. This is applied to any appointment that is broken with less than 24 hours notice, or any appt(s) that I do not show up for.

Initials \_\_\_\_\_ Date \_\_\_\_\_

Due to new patients not showing up, we will not include a cleaning in your first appointment. Also, once we have established your treatment plan, we will only schedule three (3) appointments at a time. If you no-show for two consecutive appointments, any remaining appointments will be canceled. After you have settled your balance with our Accounting Department, (this includes any Missed Appt charges) we will schedule you for one appointment at a time. For those of you this policy offends, we apologize. However, we designate periods of time to treat each of you. If someone does not make their appointment, the time another patient could possibly have utilized is lost.

Initials \_\_\_\_\_ Date \_\_\_\_\_

The quality of work done, the longevity of the work, and finally, the length of time that I will be in the chair is directly related to the health and condition of my gums. I understand that regular cleanings / exams are necessary prior to any work being done to my teeth. Toothaches will be examined, and treatment for pain will be performed. However, final treatment will not be done until gumwork is completed.

Initials \_\_\_\_\_ Date \_\_\_\_\_

I understand that if I do not keep my account current, that a 2.67% Finance Charge will be applied to my account when it reaches 60-days delinquent regardless of insurance payments. I also understand that if I do not make a payment within twenty (20) days of my billing date, a \$45 Late Payment will be applied to my account. This will take place every thirty (30) days which we do not receive a payment. Accounts with three (3) consecutive late payment charges will be reported to a credit bureau. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any further outstanding balances.

Initials \_\_\_\_\_ Date \_\_\_\_\_