Arborwalk Dental Care
Family owned, family value

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Birthday _____SSN _____

Address _____City_____State_____ Zip_____

Phones: Hm:_____ Wk:_____ Cell:_____

EMAIL:_____

Marital Status: Single _____ Married _____ Child _____ Sex: Male _____ Female _____

Occupation_____ Employer & Address_____

Spouses' Occupation_____ Employer & Address_____

How or who referred you to our office?_____

Person to contact in case of emergency? _____ Phone_____ Relationship _____

INSURANCE INFORMATION

Name of Insured _____ Insurance Company_____

Group # _____Policy/ID #_____Union or Local #_____ Group Name_____

If insured is someone other than you:

Name_____Birthday_____SSN_____ Policy/ID _____

Employer _____Relationship to patient _____

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ date of last exam_____

Are you under medical treatment now? YES NO

Are you taking any medications including non-prescription medicine? YES NO

If yes please LIST :_____

Do you smoke cigarettes? YES NO Do you use chewing tobacco? YES NO

Have you ever taken Phen-fen/Redux? YES NO Do you use controlled substances? YES NO

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING? Check all that apply

__ High blood Pressure	__ Low Blood Pressure	__ Heart Attack	__ Rheumatic Fever	__ Swollen Ankles
__ Fainting / Seizures	__ Respiratory Problems	__ Epilepsy/Convulsions	__ Leukemia	__ Diabetes
__ Kidney Disease	__ Aids or HIV Infection	__ Thyroid Problem	__ Heart Disease	__ Cardiac Pacemaker
__ Heart Murmur	__ Angina	__ Frequently Tired	__ Anemia	__ Emphysema
__ Cancer	__ Arthritis	__ Joint Replacement	__ Joint Implant	__ Hepatitis
__ Jaundice	__ Ulcers	__ STD	__ Chest Pains	__ Easily Winded
__ Stroke	__ Seasonal Allergies	__ Tuberculosis	__ Radiation Therapy	__ Glaucoma
__ Recent Weight Loss	__ Liver Disease	__ Heart Trouble	__ Asthma	__ MVP

Other _____

Patient name: _____

ARE YOU ALLERGIC TO OR HAVE HAD ANY REACTIONS TO THE FOLLOWING?

__Y __N Local Anesthetics (e.g. Novocain)
__Y __N Sulfa Drugs
__Y __N Sedatives
__Y __N Aspirin
__Y __N Latex Rubber
__Y __N Penicillin or other antibiotics
__Y __N Barbiturates
__Y __N Codeine
__Y __N Any Metals (Nickel, mercury, etc.)
Other:_____

WOMEN ONLY
__Y __N Are you pregnant
__Y __N Are you nursing
__Y __N Are you taking oral contraceptives

PATIENT DENTAL HISTORY *check all that apply*

__Y __N Do gums bleed while brushing or flossing
__Y __N Do you feel pain in any of your teeth
__Y __N Do you clench or grind your teeth
__Y __N Have you had any head/neck injuries
__Y __N Have you had difficult extractions in the past
__Y __N Have you had orthodontic treatment
__Y __N Are your teeth sensitive to hot or cold liquids/foods
__Y __N Are your teeth sensitive to sweet or sour liquids/foods
__Y __N Do you have any sores or lump near your mouth
__Y __N Do you have frequent headaches
__Y __N Prolonged bleeding after extractions
__Y __N Do you wear dentures/partials

Have you ever experienced any of the following problems in your jaw?
__Y __N Clicking
__Y __N Difficulty in opening or closing
__Y __N Pain (joint, ear, side of face)
__Y __N Difficulty in chewing

How do you rate your smile? From 1-10 1(poor) – 10 (great) _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I understand that, unless prior arrangements have been, **payment is expected at time of service.** If you have insurance, we will estimate the portion you are responsible for. However, if your insurance company does not pay in full you are responsible for the difference. We accept cash, check, Visa, MasterCard, Discover and AMEX.

I authorize Preferred Dental to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to Preferred Dental otherwise payable to me***. I understand that my dental insurance carrier my pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.***

_____ _____

Signature of patient (or parent if minor) ***date***

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Office Policy and Procedures

INSURANCE

Arborwalk Dental Care is dedicated to helping you keep your smile healthy and beautiful for a lifetime. Our office will do everything possible to help you understand and make the most of your dental insurance benefits. **As a courtesy,** we will complete and submit dental insurance forms to your insurance company to achieve the maximum reimbursement to which you are entitled and will strive to make this happen as quickly as possible.

We can only estimate the amount your insurance company will pay toward each dental procedure and are not able to guarantee what your insurance company will pay.

By signing this agreement, you are indicating that you understand and agree that you are solely responsible for all fees, including those not paid by your insurance company. These include any deductible amount, any amount that would be paid by co-insurance and insurance exclusions and/or limitations. We will file your insurance only under these terms. In some cases, your insurance company may have a maximum allowable charge for a procedure.

Please remember your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Whatever the insurance company does not pay or cover you are responsible for.

Initials _____

PAYMENT

Unless previous arrangements have been made**, payment is expected at time of service.** When multiple visits are required for treatment, your payment may be split over the number of visits required. If you have insurance, we will estimate the portion you are responsible for. However, if your insurance company does not pay in full, you are responsible for the difference. We accept cash, checks, Visa, MasterCard, Discover, AMEX and financing options are available.

Initials _____

RELEASE OF MEDICAL RECORDS

You hereby authorize Arborwalk Dental Care to release copies of any and all information in your dental/medical records to other dental/medical providers or insurance carriers as a part of, or result of your treatment and/or to any other organization for the sole purpose of obtaining payment for dental/medical services provided to or for you or your dependent/s. You release Arborwalk Dental Care, its employees and all other persons caring for you at Arborwalk Dental Care from any liability connected with the use of these records or the information in them by anyone outside of Arborwalk Dental Care. You understand that this release will remain valid until revoked in writing by you.

Initials _____

FINANCIAL RESPONSIBILITY

*By signing this agreement, you are indicating that you agree to the terms of this agreement, including being responsible for all legal fees, costs and an annual interest rate of 22% in the event that you breach this agreement. This agreement will be considered breached by you if Arborwalk Dental Care has not received payment in full within 30 days of your receipt of the final bill. In the event of breach of this agreement, all parties stipulate that Jackson County will be the county of jurisdiction to hear any dispute arising hereto.

Initials _____

2 DAY CANCELLATION POLICY

For any scheduled appointment, we require 2 business days notice if you are unable to keep your appointment. Failure to give us this notice will result in a $50.00 charge per hour scheduled. We are aware that emergencies arise, and we are not insensitive to the issues. However, if you do not call us to let us know what is occurring, we reserve the right to impose this fee. We cannot provide our patients with the level of excellence expected of us if we do not have your cooperation with respect to keeping your appointment.

Initials _____

AFTER HOUR EMERGENCY CARE

Please be advised that there is a $50.00 after hour emergency fee that will be charged if the doctor/staff come in to treat you after regular business hours. This $50.00 fee is in addition to any fees for services rendered at time of visit. This $50.00 after hour emergency fee and fee for treatment is expected at the time of service.

Initials _____

You have my permission to share my personal health information and financial information with:

_____ Initials _____

You have read, or had read to you all of the above and understand all parts of this document.

Patient Signature _____ Date_____
Custodial Parent or Legal Guardian must sign if Patient is a minor under the age of 18 or legally incapacitated.

Witness Signature_____ Date: _____
A photocopy of this authorization and assignment shall be considered as valid as the original

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You may refuse to sign this acknowledgement"

I, _____, have received a copy of this offices Notice of Privacy Practices.
(Please print name)

Signature _____ Date _____

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify)

_____ _____
Employee Name (please print) Office Name

_____ _____
Employee Signature Date