Patient Information (CONFIDENTIAL)

How did you hear about us?_____

Neighborhood Dental can now confirm appointments by Email or Text.
Please check your preference:
❑ Email ❑ Text ❑ Home Phone ❑ Cell Phone

Are you willing to be on a quick-fill list? ❑ Yes ❑ No

Patients receive a 10% discount off treatment or $20 credit for routine exam/cleaning when taking a quick fill appointment. You may receive numerous phone calls when there are cancellations.

Neighborhood Dental

Name _____ Birthdate _____ Home Phone _____ ❑ M ❑ F

Address _____ City _____ State _____ Zip _____

Email _____ SS#_____ Cell Phone _____

If Full Time Student, Name of School/College _____ City _____ State _____

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____Email _____ Cell Phone _____

Employer _____ Work Phone _____ SS#_____

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

SECONDARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

Patient Dental History

Name of Previous Dentist and Location _____Date of Last Exam _____

1. Have you ever been diagnosed with periodontal disease?_____

_____

2. How would you rate your smile on a scale from 1-10?_____

3. What changes would you make to improve your smile?_____

Over Please...

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain: _____		
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking? _____		
4. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other Antibiotics (Please list)	❑	❑
_____		
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g Nickel, Mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (Please list)	❑	❑
_____		
_____		
_____		

	Yes	No
5. Have you ever taken Fen-Phen/Redux?	❑	❑
6. Do you use tobacco?	❑	❑
7. Do you use controlled substances?	❑	❑
8. Are you taking any blood thinners?	❑	❑
9. Are you taking any bisphosphonates?	❑	❑
10. Do you have Hepatitis or Jaundice?	❑	❑
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑	❑

12. Do you have or have you had any of the following?

	Yes	No		Yes	No
High Blood Pressure	❑	❑	Emphysema	❑	❑
Heart Attack	❑	❑	Cancer	❑	❑
Rheumatic Fever	❑	❑	Arthritis	❑	❑
Fainting/Seizures	❑	❑	Stroke	❑	❑
Asthma	❑	❑	Tuberculosis	❑	❑
Low Blood Pressure	❑	❑	Radiation Therapy	❑	❑
Epilepsy/Convulsions	❑	❑	Liver Disease	❑	❑
Leukemia	❑	❑	Heart Trouble	❑	❑
Diabetes	❑	❑	Respiratory Problems	❑	❑
Kidney Disease	❑	❑	Mitral Valve Prolapse	❑	❑
AIDS or HIV Infection	❑	❑	Joint Repl or Implant	❑	❑
Thyroid Problem	❑	❑	Other (please list)	❑	❑
Heart Disease	❑	❑	_____		
Cardiac Pacemaker	❑	❑	_____		
Heart Murmur	❑	❑	_____		
Anemia	❑	❑	_____		

	Yes	No
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

HIPAA Privacy Practices

I have read a copy of this office's Notice of Privacy Practices. By signing this form, I consent for your office to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. 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.

Signature of Patient *(or Parent/Guardian of Minor)* _____ Date_____

I give my permission to discuss my dental treatment (including but not limited to: Treatment, Scheduling, Billing, Insurance, etc.) with the following: _____

_____

Signature of Patient *(or Parent/Guardian of Minor)* _____ Date_____

Neighborhood Dental

Dear patient:

In an effort to control fees, we recognize that one of the best methods is to control costs. We have therefore instituted the following financial policies as an aid in controlling expenses.

For those patients who do not have dental insurance, payment in full is required on the day services are rendered. We do offer the following plans to ease the financial stress:

- An excellent payment plan called Care Credit. If approved, your treatment can be paid interest free over a 6 or 12 month period.
- Staggered payments for large treatment plans (Bridges, Crowns, and Dentures)
- A 5% discount for cash/check same day payments on Bridges, Crowns, and Dentures

For patients with insurance, your dental benefits policy is a contract between you, your employer, and the dental benefits company. While we will assist you with understanding your benefits by verifying coverage, determining deductible amounts, pre-treatment estimates, and submitting your claims, the ultimate responsibility lies with you. If insurance does not pay the estimated portion, we will require that you pay it in full. If you have any questions regarding non-payment by your insurance, we will be happy to try to assist you. We encourage you to be aware of your dental coverage prior to any dental work.

The clinic requires a notice of at least 24 hours if the patient is unable to keep the reserved appointment time. We understand that situations outside of a patient's control can occur; however, if a third "no show" or "cancellation occurs with less than a 24-hours notice", you will be dismissed from the clinic.

Any questions regarding payments or this policy should be directed to the front office manager.

By my signature, I acknowledge that I have read and understand the office payment policy.

_____ _____

Patient or Responsible Party Date