TRENTON
FAMILY DENTISTRY

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Preferred Pronoun: _____

Work Phone: _____ Wireless Phone: _____ Married: ☐ Y ☐ N

Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Recall: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Student status if dependent over 19 (for ins) ☐ Non Student ☐ Full Time ☐ Part Time

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

DENTAL INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

DENTAL INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:
EXISTING PATIENTS Check the box next to any medication no longer being taken.

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____
6. ☐ _____
7. ☐ _____
8. ☐ _____

_____ **I do not take any medications. (Please Initial)**

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other allergies not listed above:

_____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Heart Trouble	☐	☐	Sinus Trouble
☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Joint Replacement	☐	☐	Ulcers

Other conditions not listed above:

_____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? _____

New Patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former Dentist: _____ City/State: _____

Date of last cleaning and exam: _____

Patient/Guardian Signature: _____
Date: _____

TRENTON
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Financial Agreement

Last Name: _____ First Name: _____ Birthdate: _____

Our Philosophy

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through final payments to be perceived as an extension of the dental care we provide you and your family.

Financial Partnership

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment in a timely manner. Our staff will work with you to determine financial arrangements that make sense for both of us.

FULL PAYMENT IS DUE AT TIME OF SERVICE. We accept cash, checks, and debit cards also. We accept all major credit cards with an additional 3% surcharge. We offer access to extended payment plans with credit approval.

Any balance 90 days past due will accrue a finance charge of 1.5% per month (18% APR) on. I will pay a fee of $50/hour for appointments broken without 24 hours notice. Treatment plans may change, and I will be responsible for the work actually done.

Regarding Insurance

We will work with you to file an insurance claim for your treatment, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company and you are responsible for understanding your benefits. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you.

As part of the financial arrangement process, we will estimate what your insurance company will pay. We expect payment of your out of pocket portion at time of service. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 14 days.

I have read the Financial Alliance. I understand, accept, and agree to this Financial Alliance.

Signature: _____ Date: _____

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Notice of Privacy Policies

Last Name: _____ First Name: _____ Birthdate: _____

I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. This includes but is not limited to communication with my dental insurance company, dental laboratories, and dental specialists. I also understand that I have the right to revoke permission.

Signature: _____ Date: _____

Media Release

Media Release Authorization (Optional)

I hereby authorize Trenton Family Dentistry and its authorized employees or agents, to publish my likeness, patient testimonial, information relating to the diagnosis, treatment, and health care services provided to me and which identifies my name and other personally identifiable information to be used in print media, on the radio, TV, the Trenton Family Dentistry website, blog and on the following social media platforms: Facebook, Instagram, TikTok and YouTube.

(Trenton Family Dentistry will not disclose your contact information and anything unrelated to your patient testimonial shared with Trenton Family Dentistry). I understand that any personal health information or other information released via the social media platform(s) above may be subject to re-disclosure by such social media platform(s) and may no longer be protected by applicable Federal and State privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to Trenton Family Dentistry. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for care as a patient at Trenton Family Dentistry.

I agree to the above Media Release Authorization

☐ Yes

☐ No

Signature: _____ Date: _____