H DENTISTRY

PATIENT FORM

(Circle **Y** to reply Yes, and **N** to reply No. Circle what applies: A / B / C. Fill out all lines _____.)

Last Name_____ First Name _____ Preferred Name _____

Gender _____ Married **Y** or **N** Birthdate _____ Employer: _____

Home: Phone _____ Address_____ City_____ State____ Zip_____

Phone: Cell **Text OK? Y** or **N** _____ Work_____ Email: _____

SSN: _____ Subscriber Name / SSN / DOB: _____

Y or **N :** Privacy: May we leave messages via text, phone call, unencrypted email, voicemail, or with a person at your home?

Preferred Contact Method: Text / Mail / Email / Call Cell / Call Work / Call Home

Emergency Contact_____ Relationship_____ Phone_____

If you are completing this form for another person, what is your relationship to that person? _____

How did you hear about us (We do prize drawings for existing customers who refer you to us if you write one name)? _____

Please notify us at future visits of changes in your medical health.

Y or **N :** Do you have a Panoramic X-Ray or Full Mouth X-Rays that are less than 5 years old?

Y or **N :** Do you have the smaller bitewing X-Rays that are less than 1 year old?

Name and Town of former dentist: _____

Date of last cleaning and dental exam: _____

What is the reason for your visit today? _____

How would you like to see your smile improve?_____

How do you want to whiten? ASAP and pain is ok (in office) **OR** Ideal best long term result and less pain (trays) **OR** No interest.

FYI: existing tooth repairs like fillings and crowns do not whiten, but can be replaced. Whitening results vary.

Y or **N :** Are you interested in Braces/Orthodontics by Burton Orthodontics who visit our office about every 6 weeks?

HOW CAN WE BEST EARN A "5 STAR SERVICE" ONLINE REVIEW FROM YOU?_____

Y or **N :** Are you in good health?

Y or **N :** Has there been any change in your general health within the past year?

Date of last physical examination was on _____by Dr. _____at _____.

List current conditions being treated: _____.

What applies?: high blood pressure / chest pain on exertion / short breath at mild exercise / ankles swell / heart defect / pacemaker.

Y or **N :** "Antibiotic Prophylaxis": Did your physician or surgeon say you need to take an antibiotic before all dental visits? If possible, please have them prescribe so they are more aware and can decide if/when you may stop the pre-medication. We can prescribe if you need. If we provide the premedication, we charge a small fee to cover the expense of the pills.

Y or **N :** Have you had any serious illness, operation, or been hospitalized in the past 5 years? _____.

Y or **N :** Do you smoke? (No lecture: increases risk of gum and bone disease, dry socket, and cancer)

Y or **N :** Do you have any blood concerns (anemia, aspirin, Warfarin/Coumadin)?

Y or **N :** Have you had radiation above the neck or chemotherapy for cancer?

Y or **N :** Have you had any serious trouble associated with any previous dental treatment?

List Medicines, AND the Reason for each:

_____ _____ // _____ _____

_____ _____ // _____ _____

_____ _____ // _____ _____

Circle allergies (have caused rash, hives, airway closure, or been medically tested/proven: upset stomach does NOT mean allergic)
Iodine / Codeine / Hydrocodone / Oxycodone / **Penicillin** / Other antibiotic / Other: _____ _____ _____

Y or **N :** Are you using removable dental appliances (denture / night guard / athletic guard)?
What do you like or dislike about it? _____

Do you have or have you had any of the following diseases or problems?

Y or **N :** Asthma (Bring Inhaler!)
Y or **N :** Respiratory problems
Y or **N :** Tuberculosis
Y or **N :** Unexpected weight loss
Y or **N :** Hepatitis, or liver disease
Y or **N :** Kidney trouble
Y or **N :** AIDS or HIV
Y or **N :** STD

Y or **N :** Immune disorder
Y or **N :** Difficulty healing
Y or **N :** Thyroid problems
Y or **N :** Psychological disorder
Y or **N :** Low blood sugar
Y or **N :** Diabetes
Y or **N :** Fainting spells/seizures
Y or **N :** Neurological disease

Y or **N :** Persistent swollen glands
Y or **N :** Cancer
Y or **N :** Sinus trouble
Y or **N :** Hyperacidity
Y or **N :** Cold Sores / Herpes
Y or **N :** Jaw pain
Y or **N :** Head trauma
Y or **N :** Sleep apnea

Women: Circle what applies: Pregnant / Nursing / Birth Control Pills

Please list any disease, condition, concern, or problem NOT listed above that you think I should know about?
_____ _____ _____ _____ _____

We do not provide IV sedation, but our methods prove ideal and affordable for almost all cases, including full bony impacted wisdom teeth removal, full mouth extractions and delivery of dentures, and mild to moderate anxiety.
Do you need help relaxing? No / Drive self here and home (Laughing Gas) / Anxiety (Xanax) / Anxiety and Amnesia (Halcion)
Circle BIG FEARS: See tools, See needles, Getting shots, Noises, Gagging, Vibrations, Claustrophobia

Disclaimer: All types of dental treatment come with possible risks that a patient naturally accepts which may include damage to teeth, tissue, and nerves, which may result in associated urgent care and/or irreversible results. We work hard to avoid all these risks for your health and for our enjoyment in serving you as we maintain our reputation in the region.

Signing certifies you have read and understand this form, and you will not hold the dentist, or any other member of the staff, responsible for any errors or omissions that you may have made in the completion of this form.

_____ _____
Signature of Patient or Legal Guardian Date

_____

_____

_____ _____
Signature of Dentist Date

Financial Policy for H~Dentistry PLLC

(Overhauled by Dr H on May 2021)

Thanks for choosing us to partner with you for your ideal ***oral*** health and, in turn, your ***overall*** health.

Please Initial After You Understand Each Item Below:

INITIAL:_____ You Are 100% Responsible for Your Service & Bill:

- This includes incorrect estimates and differences in payment (ie. Insurance pays less than expected or nothing at all). You are still responsible for the entire service fee.

INITIAL:_____ Payment Before Service:

- Your estimated portion is due before service is given.
- Over-payment(s) calculated after treatment or insurance payment: we call to notify you of the credit. If you do not answer, we will leave a voicemail asking you to call. Until you specify, this remainder will be kept in your account for future treatment.

INITIAL:_____ Payment After Service (Bill Owed):

- We do NOT keep your CC information.
- Any balance owed will be collected this way:
  - Request once by phone (on voicemail we will only ask you to call us; no other information)
  - Once by email (your email is CONSIDERED PRIVATE: we may email an unencrypted statement)
  - Once by mail (standard billing statement).
  - If we do not hear from you within 30 days, your account may be sent to a collection agency.

INITIAL:_____ Insurance Estimates and Differences of Payment:

- We submit to your insurance(s) free of charge so you don't have to.
- You are responsible for knowing your insurance coverage. We recommend ***you call them*** with our billing codes and fees ***to help you calculate the most accurate estimate***. We rarely pre-authorize recommended treatment as they state it is not a guarantee services will be covered by them.
- Please note that although we submit to DentaQuest CHP+, we do NOT submit to Medicaid or Medicare.

INITIAL:_____ For Procedures Requiring 2 OR MORE Visits Lab Cases):

- A. You must pay 50% (or more) of your estimated total balance before the 1st visit, and the remainder before the final visit. Some examples include: crowns, bridges, dentures, partials, night guards, and in some cases, root canals.

INITIAL:_____ Payment Plans:

- Your credit card is our only payment plan. We pay a processing fee for your convenience.
- We do not accept post dated checks.

INITIAL:_____ Discounts:

- There are no routinely offered discounts (including veterans, students, age based, retired, or otherwise).

INITIAL:_____ 2-8 Hour Appointments:

- Your **ENTIRE ESTIMATED PORTION** for the day of treatment will be collected **WHEN YOU SCHEDULE** your LONG appointment.
- Minimum ONE WEEKnotice to reschedule without penalty fee of $75 per hour scheduled.

INITIAL:_____ Cancellation or No Show Fees:

- If you do NOT show for your appointment, *or cancel within 24 hours* for ANY reason:
  - $35.00 fee for checkups or treatment appointments under 90 minutes.
  - $150-$600 for 2-8 Hour Appointment: $75 PER HOUR scheduled.

Appointment Reminders are sent via email/text 10 days & 3 days prior to your appointment.

Print Name	**Signature**	**Date**