Patient Information (Confidential)

Name_____ Birth date_____

Address _____

City_____State_____Zip_____

Cell # _____ Home phone #_____ Soc. Security #_____

Email _____

How did you hear about our office?

_____

Emergency Contact: _____ Phone #_____

Responsible Party

Name of person responsible for this account (if different than patient)

_____

Relationship to patient_____ Phone #_____

Address_____

Insurance Information

Name of insured _____Relationship to patient_____

Birth date_____

Soc.security#_____Employer_____

Insurance co._____ Tel. #_____

Grp. #_____Policy/I.D. #_____

Ins. co. address_____

City_____State_____Zip_____

Do you have any additional insurance Yes / No (If yes, complete the following.)

Name of insured _____ Relationship to patient_____

Birth date_____ Soc. security #_____

Name of employer_____

Insurance co._____ Tel. #_____Grp. #_____

Policy/I.D. #_____ Ins. co. address_____

City_____State_____Zip_____

X_____

Signature of patient or parent if minor Patient number

*Do you like your smile?*_____

What would you change about your smile? _____

Medical History

Date of most recent dental exam/cleaning _____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment _____/_____/_____ I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo.

*What is your Immediate concern ?*_ _____

Are you under a physicians care now? Physicians name: _____

Have you ever been hospitalized or had a major surgery? If yes, explain: _____

_____

Please list medications you are taking (pills or drugs; We can make a copy if you have a list.)

_____

_____

Do you take or have you taken Fosamax, Boniva, Actonel or any other medicines containing bisphosphonates (for Osteoporosis)?

_____

Do you take or have you taken Blood Thinner? (Coumadin, Warfain, Heparin, etc)

_____

_____

Do you use tobacco? _____ Do you use controlled substance? _____

Are you allergic to any of the following? (cirlce all that apply) Aspirin Metal Penicillin Latex other medicine _____

WOMEN: Are your pregnant or nursing? _____

Do your gums bleed or are they painful when brushing or flossing? _____

Have you ever been treated for gum disease? _____

Are any teeth sensitive to hot, cold, biting, sweets? _____

Do you clench your teeth in the daytime or grind during sleep? _____

Do you have any problems with sleep or wake up with an awareness of your teeth or jaw pain? _____

Do you wear or have you ever worn a bite appliance? _____

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

AIDS/HIV __
Alzheimers / Dementia __
Anaphylaxis __
Anemia/blood disorder__
Angina __
Arthritis__
Artificial heart valve __
(heart valve replacement)
Artificial joints__
Asthma__
Blood disease __
Blood transfusion __
Breathing problems__
Bruise easily __
Cancer __
Chemotherapy__
Chest pains __
Cold sores__
Congenital heart disorder __
Convulsions __
C.O.P.D ___

Diabetes__
Emphysema__
Endocarditis ___
Epilepsy / Seizure __
Excessive bleeding __
Fainting spells __
Frequent cough __
Herpes __
Glaucoma__
Heart attack__
Heart murmur __
Heart pacemaker __
Heart disease __
Hepatitis A B or C __
High blood pressure__
High cholesterol__
Hives or rash __
Hypoglycemia __
Kidney Disease__
Leukemia __
Liver disease __

Low blood pressure__
Lung disease __
Mitral Valve prolapse
Osteoporosis__
Pain in jaw joints__
Psychiatric Care__
Radiation Treatments__
Rheumatic fever__
Scarlet fever __
Shingles __
Sickle cell disease __
Sinus trouble __
Spina Bifida __
Stroke __
Thyroid Disease __
Tonsillitis __
Tuberculosis __
Tumors __
Ulcers __
Venereal Disease __
Yellow Jaundice __

PATIENT SIGNATURE _____ *DATE* _____

Notice of Privacy Practices-Acknowledgement

We keep a record of the healthcare services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.
Our Notice of Privacy Practices describes in detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge that I have read and understand my rights contained within the Notice of Privacy Practices. I am aware that this office keeps a copy of these available for me to read when requested.

Signature: _____ *Date:* _____

Release of Dental Information

I authorize the release of medical/dental information to my primary care or referring physician, as well as to consultants if needed, and as is necessary to process any insurance claims, insurance applications and prescriptions.

Signature: _____ *Date:* _____

Park Dental Group

Office Policies

Thank you for choosing Park Dental Group for your Dental needs.

OFFICE HOURS:

Our current hours are **Tuesday & Thursday** 7am to 4pm and **Wednesday & Friday** 8am to 5pm.

CANCELLING / BREAKING APPOINTMENTS:

If you cancel an appointment with *less than 24 hours notice you will be charged a fee*. If you no show for an appointment, Park Dental Group may refuse treatment.

The fees for Canceling / Breaking appointments are as follows:

0-1hr appointment - $35
1-2hr appointment - $50
2 or more hour appointment - $50+ and may be required to prepay for next appointment.

INSURANCE FILING:

****All payments / co-pays for services rendered are due at time of service****

For all returned checks there is a $30.00 fee.

We will make every attempt to get your claims paid. Insurance companies will not guarantee payment or eligibility but we will make every attempt to be as accurate as possible with estimations. *If an insurance company refuses payment on a claim you will be responsible for any remaining balance not covered*.

Most common denial by insurance companies:

***ALTERNATE BENEFIT ON POSTERIOR RESIN : This is when an insurance company decides to down grade a resin (tooth colored filling) to an amalgam filling. *If your insurance company chooses to pay the alternate benefit you will be responsible for the difference, usually between $10 - $30 per filling*.

***WE DO NOT DO AMALGAM (SILVER FILLINGS)**

Print Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____