

# Access Dental Care

We are pleased to welcome you to our practice. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.



## Patient Information

Patient Name: \_\_\_\_\_ Prefers to be Called By: \_\_\_\_\_  
Sex:  Male  Female Status:  Married  Single  Child  Other \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone (H): \_\_\_\_\_ (C): \_\_\_\_\_ (W): \_\_\_\_\_ Ext: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
In case of emergency, contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_



## Responsible Party Information (If Other Than Patient)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Sex:  Male  Female Status:  Married  Single  Child  Other \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ Ext: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_



## Insurance Information

**Primary Insurance Information:** \_\_\_\_\_ ID # / SS #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Is insured the patient?  Yes  No  
If not, patient's relationship to insured:  Spouse  Child  Other: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
**Secondary Insurance Information:** \_\_\_\_\_ ID # / SS #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Is insured the patient?  Yes  No  
If not, patient's relationship to insured:  Spouse  Child  Other: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Signature of Patient or Legal Guardian

Patient/Legal Guardian Name Printed

Date

# Access Dental Care



## Referral Information

Whom may we thank for referring you to our practice? Name of person or office referring you to our practice: \_\_\_\_\_



## Dental History

Patient Name: \_\_\_\_\_  
Title First Middle Last

Reason for Today's Visit: \_\_\_\_\_

Former Dentist: \_\_\_\_\_ Address: \_\_\_\_\_

Date of last dental care: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Have you ever had a bad dental experience? If yes, explain: \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Do you snore                   |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Sensitivity when biting        | <input type="checkbox"/> Do you have Sleep Apnea        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to hot or cold     | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_ Are you happy with your smile? \_\_\_\_\_



## Medical History

Physician's Name: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe: \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates: \_\_\_\_\_

**(Women)** Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had any of the following:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath       |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                 |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet / Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit             |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis               |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Chemical Sensitivity | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                     |
| <input type="checkbox"/> Cholesterol (High)      | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease          |

OTHER PROBLEMS NOT LISTED ABOVE: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

Have you ever taken any Bisphosphonate Bone Supplements? If so, for how long? (ex. Fosamax, Zometa, Aredia, Didronel, Actonel, Skelid, Boniva) \_\_\_\_\_

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

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# Access Dental Care



## Insurance Information

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense. **Insurance is a method of payment not a method of treatment.** Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay. **We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".**

*Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.*

It often takes us a considerable amount of time to try to collect your insurance payment for you. We often need your help to discuss your situation directly with your insurance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, we cannot render services on the assumption that our charges will be paid by an insurance company. In addition, this form also authorizes this practice to submit insurance claim forms and receive payments directly from the Insurance carrier with the notation "SIGNATURE ON FILE".



## Financial Agreement

If an account is outstanding for more than sixty (60) days, a monthly service charge of 1.5% may be added to the balance. If the account is not cleared within the time specified, the account will be turned over to our collection service with additional charge of \$35 towards the pending balance and a report may be filed with a credit servicing agency, such as Equifax. **Insurance co-payments and deductibles are due at the time of service.**

### I Understand That Payment Is Due At Time of Service

Signature of Patient/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_



## Consent

Yes No

- I hereby authorize and direct the dentists of Access Dental Care and/or dental auxiliaries of their choice, to perform treatment that is necessary or recommended.
- I authorize my Dentist(s) to release treatment records/ x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or treatment.

### **I acknowledge that the practice may send the following electronic communications:**

- Information about my invoice or accounts payable upon request, to patient/legal guardian
- Information about a specific dental visit
- Digital x-rays, referrals and/or orders to a dental specialist about treatment

I have read and understand the above and acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

Signature of Patient or Legal Guardian

Patient/Legal Guardian Name Printed

Date



## Cancellation or Broken Appointment

Your time is as valuable as ours. We make every effort to see you at your reserved time. We apologize in advance if you are not seen exactly at your scheduled time; please understand that we do try to work- in dental emergencies.

As a courtesy we attempt to confirm each scheduled appointment, however, as the patient you are responsible to keep up with your reserved time and are still subject to the cancellation/ broken appointment fee of \$35 per half hour should you not make it to your appointment. **INSURANCE COMPANIES DO NOT PAY YOUR BROKEN APPOINTMENT FEES.** Please inform us if any address or contact information needs to be updated. The office must be notified within 48 business hour if you wish to make any changes to your scheduled appointment.

### Extensive Treatment Scheduling

A 10% deposit is required for all restorative procedures. A \$150 deposit is required for all procedures reserved for more than 90 minutes. This amount will be applied to your out-of-pocket expenses not covered by your insurance. Should you miss your appointment without cancellation 48 hours before; your deposit will be forfeited.

### Privilege of a Saturday Appointment

At Access Dental Care, we understand how difficult it can be for patients and their families to find time for scheduling dental appointments. After school activities, sports teams, work, family and social obligations all require time from packed schedules. Our flexible scheduling is part of our dedication to serving our patients and their families. We want you to get the best dental care you need, when you need it. We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

#### **Failure to give 48 hour advance notice:**

- No privilege of a Saturday appointment for future appointments, until 3 consecutive completed appointments

#### **Definition of "Broken Appointment": A broken appointment is when you**

- Cancel or reschedule an appointment with less than 48 hour notice
- Do not show up for the scheduled appointment

I have reviewed, understand, and agree to comply with the above office policies.

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Signature of Patient or Legal Guardian

Patient/Legal Guardian Name Printed

Date