Patient, Pharmacy and Insurance Information

Patient Information

First Name: _____Middle Name:_____Last Name:_____

Address:_____City:_____State:_____Zip:_____

Social Security #: _____ Date of Birth:_____

Preferred Phone #: _____ Is this a mobile number? ○Yes ○ No

Sex: ○Male ○Female ○Unspecified Primary Language: ○ English ○Spanish Other: _____

Emergency Contact: _____ Relationship:_____

Emergency Phone #: _____

Responsible Party

First Name: _____Middle Name: _____Last Name:_____

Address:_____City:_____State:_____Zip:_____

SS#: _____Phone #: _____Date of Birth: _____

Sex: ○Male ○Female ○Unspecified

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Address:_____

Primary Dental Insurance

Is subscriber the same as patient? Yes No

Subscriber Information:

First Name: _____Middle Name: _____Last Name:_____

Subscriber SSN: _____Date of Birth: _____

Employer Name: _____Insurance Company: _____Ins Phone Number: _____

Subscriber ID/Policy Number:_____Group Number:_____

Patient Relationship to Subscriber: Self Spouse Child Other Dependent

Secondary Dental Insurance

Is subscriber the same as patient? Yes No

Subscriber Information:

First Name: _____Middle Name: _____Last Name:_____

Subscriber SSN: _____Date of Birth: _____

Employer Name: _____Insurance Company: _____Ins Phone Number: _____

Subscriber ID/Policy Number:_____Group Number:_____

Patient Relationship to Subscriber: Self Spouse Child Other Dependent

Health History

Reason for Visit: Broken Tooth Check-up Cosmetic Dentures Tooth Pain Other: _____

Are you under the care of a primary physician? Yes No

Primary Physician's Name: _____Physician's Phone #_____Date of Last Physical: _____

Have you ever been hospitalized? Yes No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)? No Yes How Long? _____

Do you require antibiotics prior to dental procedures? Yes No

Are you allergic or have you had an adverse reaction to any of the following?(please circle or write)

None Amoxicillin Aspirin Codeine Epinephrine Latex Metals Novocain Penicillin Sulfa

Other:_____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

_____

Check any conditions that apply to you: None

- O Alcoholism
- O Allergies or Hives
- O Anemia
- O Arthritis
- O Artificial Joint/Pins
  Type:_____
  Age:_____
- O Aspirin Therapy
- O Asthma
- O Blood Thinners
- O Blood Transfusion
- O Breathing Problems
- O Dialysis
- O Cancer
  Type:_____
- O Chemotherapy
- O Cortisone treatment
- O Coumadin Therapy
- O Dementia
- O Diabetes
  Type:_____
- O Drug Addiction
- O Epilepsy
- O Excessive Bleeding
- O Fainting/ Dizziness
- O Hearing Impairment
- O Heart Murmur
- O Heart Surgery
  Date:_____
- O Hemophilia
- O Hepatitis
  Type:_____
- O High Blood Pressure
- O HIV/AIDS
- O Kidney Disease
- O Liver Disease
- O Low Blood Pressure
- O Lung Disease/ COPD
- O Lupus
- O Mitral Valve Prolapse
- O Mobility Impairment
- O Non-dental Implants
  Type: _____
- O Organ Transplants
  Type:_____
- O Pacemaker
- O Psychiatric Care
- O Radiation Therapy
- O Rheumatic Fever
- O Seizures
- O Sexually transmitted disease
- O Sinus problems
- O Stomach problems
- O Stroke
  Date:_____
- O Thyroid disease
- O Tuberculosis (TB)
- O Ulcers
- O Visual Impairment
- O Other disease/ illness
  Type:_____

Dental History

Date of Last Dental Visit: _____Date of Last Dental X-rays: _____

Have you ever been treated for periodontal (gum) disease? Y/ N

Have you ever had Novacaine or other local anesthetic? Y/ N

How happy are you with your smile (1-10)? _____

Are you currently wearing dentures? Y/ N Age _____

Please check any conditions that apply to you below?

- O Pain in Jaw (TMJ)
- O Senstitive Teeth
- O Teeth Grinding/ Clenching
- O Broken/ Loose teeth
- O Use Tobacco Products
- O Difficulty Chewing/ Swallowing
- O Mouth Sores
- O Swollen/Bleeding gum

Women Patients Only

Are you currently pregnant? Y/ N Estimated Due date: _____

Are you nursing? Y/ N Are you taking birth control Prescriptions? Y /N

***NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Please consult your physician/ gynecologist for assistance regarding additional methods of birth control.

Patient's Signature_____ Date: _____

Dr's Signature:_____ Date: _____

Financial Policy Acknowledgement

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our office.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment options. Check policy: If your check is returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of **$25**.

INITIAL _____

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a missed appointment fee of **$50**. Should you find it necessary to reschedule an appointment, please provide us with a notice of two business days to avoid being charged a missed appointment fee.

INITIAL_____

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense.

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

Patient/ Parent/ Guardian Signature:_____ Date:_____

Important Facts About your Dental Insurance

- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
- It is your responsibility to understand the type of dental insurance you have, and the benefits selected by you and/or your employer.
- You, not the insurance company are responsible for the fees of services rendered.

Patient/ Parent/ Guardian Signature:_____ Date:_____

Patient Signatures

Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claims. This information will be used exclusively for the purpose of evaluating and administering claims for benefits I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature: _____ **Date:** _____

If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party Section.)

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____ Relationship to patient: _____

Consent to obtain patient medication history (Optional)

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my presseription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescribeption information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature: _____ **Date:** _____

Payment, Insurance and Financial Arrangement Policies (signed by ALL patients)

By signing below, I acknowledge that I received the Financial Policies forma and agreed to abide by such policies.

Signature: _____ **Date:** _____

If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party Section.)

Notice of Privacy Practices (must be signed by ALL patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

Signature: _____ **Date:** _____

If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party Section.

———————————————————For Office Use Only———————————————————

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

Agreement to Receive Electronic Communication

(Initial below)
I _____ DO AGREE
I_____ DO NOT AGREE

That NORTH BAKERSFIELD DENTAL may communicate with me electronically at the email address and/or mobile phone number listed below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication: (Initial below)
____Text Messaging
____ Email

I would like to receive:
____ Appointment Reminders/Recall Visits
____ Information regarding insurance/billing
____ Requests for Patient Satisfaction online reviews

PHONE NUMBER:_____

EMAIL ADDRESS:_____

I can withdraw my consent to electronic communications at anytime by calling:
NORTH BAKERSFIELD DENTAL @ (661)399-1058

Patient Signature:_____ Date:_____