Founders Dental
A smile you can be proud of

Patient Information

Name: _____
Last First Middle

E-Mail Address:_____ Gender: M____F_____Identify As_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth: ___/___/_____Social Security Number: _____-___-_____Driver's License or ID Number:_____
MM / DD / YYYY

Responsible Party Information (If Patient is a Dependent)

Name: _____
Last First Middle

Relationship to Patient:_____ E-Mail Address: _____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth:_____/___/_____Social Security Number:---------- Driver's License or ID Number:_____
MM / DD / YYYY

Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: _____
Last First Middle

Primary Policy Holder's Date of Birth:_____/___/_____ Primary Policy Holder's SS/ Member ID Number:_____-____-_____
MM / DD / YYYY
Primary Policy Holder's Employer:_____

Insurance Company Name:_____Group Number:_____Insurance Company Phone: (_____)_____

Insurance Company Address:_____
Street City State Zip

Emergency Contact Information

Local Friend:_____Emergency Contact Phone: (_____)_____

Emergency Contact Address:_____
Street City State Zip

Getting to Know You

Why did you select our office?_____Whom May we thank for referring you?_____

Is another member of your family already a patient with our practice? ❑ Yes ❑ No Family Member?_____

When was your last dental visit? _____

When was the last time you had complete dental x-rays taken?_____Have you ever had any teeth removed? _____

How long have these teeth been missing? _____

How Have these teeth been replaced? ❑ Bridge ❑ Partial ❑ Denture ❑ Implants ❑They have not been replaced

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

_____

SIGNATURE OF RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT** **DATE**

MEDICAL HISTORY – Please Answer ALL Questions

Name:_____ **Date of Birth:**_____ **Age:**_____

Height:_____**ft.**_____**in.** **Weight:**_____**lbs.**

Primary Care Physician:_____ **Phone/Contact:**_____

1. Do you consider yourself a healthy person? ……❑ Yes ❑ No
2. Would you like a comprehensive oral cancer exam?……❑ Yes ❑ No
3. Have you been under the care of a medical doctor during the past two years? ……❑ Yes ❑ No

   If yes, for what reason?_____ Est. Last Physical Exam Date:_____
4. Do you consider your teeth, gums and mouth to be healthy and problem free? ……❑ Yes ❑ No 5. Do your gums bleed at any time? ..... ❑ Yes ❑ No
6. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? .....❑ Yes ❑ No

   If yes, please list._____
7. Have you ever had excessive bleeding requiring special treatment? ……❑ Yes ❑No
8. Women: Are you or might you be pregnant? …… ❑ Yes ❑ No Estimated Due Date_____
9. Check any and all of the following which you have a history of or currently under treatment for:

❑ Heart Disease or Attack	❑ Ulcers	❑ HIV Positive (AIDS)
❑ Tuberculosis (TB)	❑ Shortness of Breath	❑ Cancer or Tumor
❑ Asthma	❑ Hepatitis (circle: Type A, B or C)	❑ High Blood Pressure
❑ Rheumatic Fever	❑ Liver Disease	❑ Heart Murmur/Mitral Valve
❑ Scarlet Fever	❑ Diabetes	❑ Bruise Easily
❑ Artificial Heart Valve	❑ Thyroid Disease	❑ Drug Addiction
❑ Heart Pacemaker	❑ Chemotherapy (Cancer, Leukemia)	❑ Hemophilia
❑ Heart Surgery	❑ Arthritis	❑ Cold Sores or Fever Blisters
❑ Artificial Joint	❑ Cortisone Medication	❑ Epilepsy or Seizures
❑ Stroke	❑ Glaucoma	❑ Nervousness
❑ Kidney Trouble	❑ Pain in Jaw Joints	❑ Psychiatric Treatment

Do you have or have history of any surgery, disease or medical condition not listed on this form? .....❑ Yes ❑ No

Please list:_____

_____

10. List all Prescription Medications you are taking at this time. ❑None _____

_____

11. Do you use any type of tobacco product regularly? ..... ❑ Yes ❑ No
12. Do you use or have you ever used recreational drugs?..... ❑ Yes ❑ No
13. Do you clench or grind your teeth? ..... ❑ Yes ❑ No
14. Do you or have you been told you snore loudly (enough to bother others)? .....❑ Yes ❑No
15. Are you aware or have you been told you stop breathing or are choking while sleeping? ……....❑ Yes ❑ No
16. Do you often feel tired, fatigued or can't stay awake during the daytime? ..... ❑ Yes ❑ No
17. Do you currently use or have been diagnosed to need a CPAP breathing machine to sleep? .....❑ Yes ❑ No

Signature:_____ **Date:** _____

Updates (date & initial) _____

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can be of service to you as comfortable as possible.

1. Please rate the following statements regarding what is most important to you in dental care so we can best serve you: (#1 being the most important)

   ____Long-Term Preventative Care…I have healthy teeth and want to keep them that way.

   ____Creating a Comprehensive Overall Dental Care Plan…I want to Invest in my Teeth and Appearance

   ____Dental Care is budget driven. I will have to plan financially for any treatment beyond my immediate needs.

   ____ Other Goals: _____

2. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)

   1 2 3 4 5 6 7 8 9 10

3. Are you concerned about: (please circle yes or no)

Replacing missing teeth	Yes	No	Straightness of your teeth or bite	Yes	No
Eliminating any cavities	Yes	No	Snoring at night	Yes	No
Gum disease	Yes	No	Color of your teeth	Yes	No
Bad breath	Yes	No	Appearance of your smile	Yes	No

4. Are you or anyone in your family interested in a **complimentary** orthodontic (Braces or Invisalign) consultation with our Orthodontist? Yes No

We know dental care can be very stressful for most people. Please share your concerns and past experiences to help guide us in serving you and your family more effectively.

5. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)

   1 2 3 4 5 6 7 8 9 10

6. When we review your treatment plan with you, would you like to know (please check one):

   ____I am a big picture type person, I prefer to review the plan looking at all the things that need to be done.

   ___I am a detail-oriented person, I prefer to approach each treatment step along the way

7. Please briefly describe any bad dental experiences you have had: _____

_____

_____

_____

THANK YOU

DENTAL INSURANCE POLICY

Founders Dental proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service. Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due Immediately upon receipt.** I understand that I am responsible for all costs of collection including attorney fees. Collection fees of 30% and court costs. I understand that an unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employees, agents and assignees to contact me via e-mail, text messaging and to cellular devices.

----------PATIENT ACKNOWLEDGMENT AND AUTHORIZATION----------

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Founders Dental. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature:_____Date: _____

APPOINTMENT DEPOSIT REQUIREMENT

Founders Dental requires a minimum $50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of $500 or more. The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Founders Dental requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject to our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

Saturday appointments require a $25 deposit because our providers and dental assistants reserve the appointment time specifically for you. The deposit operates as a credit on the account to secure future Saturday appointments. **The deposit requirement is subject to our Cancellation Policy.**

I understand and agree.

Signature:_____Date: _____

CANCELLATION POLICY

Founders Dental makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 48 hours' notice if you are unable to keep your scheduled appointment**. **We reserve the right to charge a cancellation fee of $50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature:_____Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I,_____, have had the opportunity to review Founders Dental's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature:_____Date: _____

Founders Dental

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed out notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected heal information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we hall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allow for the use of the information of treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____