Chelsea Family Dentistry, PC

PATIENT INFORMATION

Today's Date __________________

Name ____ Prefer to go by: ________________ Male _____ Female _____

Marital Status (please check box): Single [ ], Married [ ], Widowed [ ], Divorced [ ], Other [ ]

Date of Birth _________________ Social Security # ____________________________

Address ____ City, State & Zip ________________________________

Email__________________________________

Home Phone ______________________ Work Phone ______________________ Cell or Message Phone _____________________

Have other members of your family been to our office? Yes [ ], No [ ] _________________________ Relation____________

Referred to our office by: ______________________________________

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party (guardian) ________________________

Relationship to Patient__________________ Date of Birth _______________Social Security #_________________________________

Address (if different than patient) _______________________________________City, State & Zip ______________________________

Occupation ________________________ Employer __________________________ Employer / Work Phone ______________________

How would you like to pay for your portion of the provided services? Cash [ ], Check [ ], Credit Card [ ] Other [ ] _________

RESPONSIBLE PARTY'S SPOUSE

Name of Responsible Party (guardian) _________________________ Date of Birth _________Social Security #_________________

Address (if different than patient) ____ City, State & Zip ____________________________

Occupation ________________________ Employer __________________________ Employer / Work Phone ______________________

DENTAL INSURANCE

Insurance Company ____________________________________ Insured Name ____

Insured DOB ___________________________________ Subscriber Number ____

May be Social Security number

Group # ______________________ Employer _______________________________ Employer Phone Number_______________

Insurance Co. Address ____ City, State & Zip _________________________

Insurance Co. Phone # _________________________________

SECONDARY DENTAL INSURANCE

Insurance Company ____________________________________ Insured Name ____

Insured DOB ____________________________________ Subscriber Number ____

May be Social Security number

Group # ______________________ Employer _______________________________ Employer Phone Number________________

Insurance Co. Address ____ City, State & Zip ________________________

Insurance Co. Phone # _________________________________

Please take this page to Front Desk Person, then complete the remainder of pages. Thank You

MEDICAL HISTORY for (Patient Name): ________________________________

Please keep us updated on any future changes to your medications, allergies or medical history.

General Health: Good [ ], Fair [ ], Poor [ ]

Physician's Name ______________________________________ Last Complete Physical ____________________________

Recently hospitalized or past major surgeries? ____

____

Are you currently on any medications? Yes [ ] No [ ]

If 'Yes', please list medications and purpose: ____

____ ____

____ ____

____ ____

Do you have to pre-medicate with antibiotics before dental treatment? Yes [ ] No [ ]

If so what kind? ___________________________

Please mark the boxes, if you are *currently, or have ever been diagnosed or treated* for:

[ ] Aids / HIV
[ ] Anemia
[ ] Arthritis
[ ] Artificial Joints
[ ] Asthma
[ ] Blood Disease
[ ] Cancer (Type)
[ ] Diabetes
[ ] Dizziness
[ ] Epilepsy
[ ] Excessive Bleeding
[ ] Excessive Thirst
[ ] Excessive Urination
[ ] Fainting
[ ] Glaucoma
[ ] Growths
[ ] Hay Fever
[ ] Head Injuries
[ ] Heart Disease
[ ] Heart Murmur

[ ] Hepatitis
[ ] High Blood Pressure
[ ] Jaundice
[ ] Kidney Disease
[ ] Liver Disease
[ ] Mental Disorders
[ ] Mitral Valve Prolapse
[ ] Osteoporosis
[ ] Nervous Disorders
[ ] Pace Maker
[ ] Pre-Med
[ ] Pregnant currently, Due: _________

[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Rheumatism
[ ] Sinus Problems
[ ] Stomach Problems

[ ] Stroke
[ ] Tuberculosis
[ ] Tumors
[ ] Uses Tobacco Products
[ ] Ulcers
[ ] Venereal Disease

Allergic to any medications
[ ] Codeine
[ ] Penicillin
[ ] Latex
[ ] Sulfur Drugs
[ ] Local Anesthetics
[ ] Other_______________
[ ] Other_______________

[ ] Allergies: _________________
____
____

Is there anything that you prefer to talk to the Doctor in private about? ____

Release of Patient Information:

This is to inform you that Chelsea Family Dentistry, PC will not release any information about you or your account and/or dental treatment to ANYONE without written notice from you. This includes your family. If there is anyone that we may discuss these matters with please list them below:

Name: ________________________________ Relationship to Patient _____________

Name: ________________________________ Relationship to Patient _____________

Name: ________________________________ Relationship to Patient _____________

Please sign below as an acknowledgement that you were informed of our policy.

Patient /Parent/Guardian Signature: ________________________________

DENTAL HISTORY for (Patients Name): ________________________________

Reason for today's visit? ____

Last Dental Visit ___________________________________ How often do you brush? _______________________________

Have you ever had a serious problem associated with a previous dental treatment? [ ] Yes [ ] No

If 'Yes', please explain ____

What dental aids do you use? [ ] Floss, [ ] Water Pick, [ ] Toothpick, [ ] Electric / Sonicare Toothbrush, [ ] Perio Aid, [ ] Other

Are you familiar with the term 'Preventive Dentistry'? . . . . [ ] Yes [ ] No

When used properly, do you believe in the dental benefits of Fluoride? . . . . . [ ] Yes [ ] No

Do you plan on maintaining your teeth for the rest of your life? . . . . [ ] Yes [ ] No

Please check any of the following which apply to you:

[ ] Gums bleed during brushing or flossing

[ ] Gums feel tender or swollen

[ ] Pain with brushing or flossing

[ ] Frequent sensitivity to cold, hot or sweets

[ ] Usually break fillings or teeth

[ ] Pain with biting or chewing

[ ] Jaws frequently feel tired or sore

[ ] Regularly clench or grind your teeth

[ ] Bad odors or tastes in mouth

[ ] Currently (or previously) used a mouthguard or splint

[ ] Frequent cold sores, blisters or other oral / lip lesions

[ ] Food frequently gets caught between teeth

[ ] Previous (or current) Periodontal (gum) surgery

[ ] Previous (or current) Orthodontics (braces)

[ ] Previous (or current) injury or trauma to your teeth, mouth or face

[ ] Previous (or current) biopsy of the mouth, lips or face

[ ] Either took fluoride as a child, or grew up in a fluoridated community

[ ] Currently using a Tartar Control, Whitening or Baking Soda Toothpaste

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Chelsea Family Dentistry, PC. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Chelsea Family Dentistry, PC to release any information regarding my dental/medical history, diagnosis and copies of all x-rays and all treatment notes to third party payers and/or other dental/health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Chelsea Family Dentistry, PC. I agree to be responsible for payment on services rendered or rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment. **Patients are responsible for knowing their insurance policy**. Any treatment we present to you is just an ESTIMATE and not a guarantee of payment, the insurance company informs us that, "this is not a guarantee of benefits until we actually receive a claim and process the claim".

Responsibility for Payment:

In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection of sums due and unpaid for the work herein set forth.

Minors or children, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

X ________________________________ ________________________________ __________

Signature of patient, parent or guardian **Print name of patient, parent or guardian** **Date**

CHELSEA FAMILY DENTISTRY, PC OFFICE POLICIES

Patients Name: ____

PAYMENT. Payment in full is required at the time of service. For your convenience, we accept cash, debit, and credit cards, including Visa, Master Card, and Discover. We may at times offer a very simple payment plan to patients of record **who have demonstrated a one to two year history of good credit at our office**. The maximum amount of credit **we may offer upon approval is six (6) times the amount of your chosen monthly payment**. For example, if you choose to make monthly payments of $100, we would offer you and your family treatment up to $600. We would need to halt treatment on a temporary basis, when you come near or exceed the credit-limit that you had set for yourself. On major restorative or cosmetic work such as crowns, veneers, bridges, implants or dentures; you would be asked to pay half the cost of the treatment at the time of service. , Financial arrangements are to be made before treatment is rendered

DIVORCE. In case of divorce or separation, the **parent authorizing treatment for child(ren)** will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect that amount from the other parent.

INSURANCE. Dental Insurance never pays for 100% of all dental services. As a courtesy, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. At the time of service, we will request from you an initial payment, the estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays. After your dental insurance settles your claim, any remaining balance is your responsibility. Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility.

Questions and concerns with your dental coverage and the payment of your claim(s) are the sole responsibility of the insured, and should be resolved with the insured's employer and/or dental insurance company. Your coverage is a result of the contract between the insured's employer and the dental insurance company, and our office has no control over payment or non-payment of your claims. As your dental care provider, we advise treatment that is in the best interest of your medical and dental health. Insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs.

It is the sole responsibility of you, the patient, to familiarize yourself with the rules, terms, exclusions, clauses, and benefit limitations of your dental insurance policy.

ESTMATES AND FEES. Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed upon your approval.

AGED ACCOUNT. The total balance on your account, after claim settlement, is due immediately upon receipt of statement. Failure to keep this account current may result in Chelsea Family Dentistry, PC being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees, finance charges, collection agency fees, attorney's fees and court costs.

FAILED OR CANCELLED APPOINTMENTS. . If unable to keep a scheduled appointment, we ask that you provide us with 24 hours notice as a courtesy. **Notice of less than 24 hours will result in a minimum charge of $25.00, the amount to vary depending on the magnitude of the failed appointment. We will not offer appointments to patients who fail multiple appointments without having given us proper notice. You may leave a message on our after-hours message phone, if you find out that you are unable to honor an appointment after our office has closed for the day.**

NOTICE OF PRIVACY PRACTICES (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office and attached to the New Patient paperwork which you are being asked to complete in our office. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices.

I have read, understand, and agree to all the above.

X________________________________ ________________________________ ________

Signature of Person Responsible **Printed Name of Person Responsible** **Date**