Open and Affordable Dental®

New Patient Form

How did you hear about us? ☐ Internet ☐ Mailer ☐ Insurance ☐ Friend (Friend's name) _____

Patient's Name _____ Soc. Sec. # _____

Last Name *First Name* *M.I.*

Address _____

City _____ State _____ Zip _____

Mobile Phone _____ Other Phone _____

Email _____

Sex ☐ M ☐ F Birthdate _____

Employer _____ Occupation _____

Emergency Contact Name/Number _____

Primary Insurance

Person Responsible for Account _____

Last Name *First Name* *M.I.*

Relation to Patient_____ Birthdate _____Social Security #_____

Address (If different from patient)_____Phone_____

City_____State_____Zip_____

Email_____

Person Responsible Employer _____ Occupation_____

Insurance Company _____ Phone _____

Insurance Email _____

Contract #_____Group #_____Subscriber #_____

Name of other dependants under this plan _____

Additional Insurance

Person Responsible for Account_____

Last Name *First Name* *M.I.*

Relation to Patient_____ Birthdate_____Soc. Sec. #._____

Address (If different from patient)_____Phone_____

City_____State_____Zip_____

Email_____

Person Responsible Employer_____Occupation_____

Insurance Company_____Phone_____

Insurance Email_____

Contract #_____Group #_____Subscriber #_____

Name of other dependants under this plan _____

***Required Fields

Medical History

Are you under a physician's care now? ☐ Y ☐ N If yes: _____

Have you ever been hospitalized or had a major operation? ☐ Y ☐ N If yes: _____

Have you ever had a serious head or neck injury? ☐ Y ☐ N If yes: _____

Are you taking any medications, pills, or drugs? ☐ Y ☐ N If yes: _____

Are you taking blood thinners e.g. Warfarin, Coumadin, or Xarelto? ☐ Y ☐ N If yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Y ☐ N If yes: _____

Do you use tobacco? ☐ Y ☐ N

Do you have any artificial joints? ☐ Y ☐ N

Do you have or are you being treated for High Blood Pressure? ☐ Y ☐ N

Do you take or have you taken, Phen-Fen or Redux? ☐ Y ☐ N

Women: Are you….

☐ Pregnant/Trying to get pregnant? If yes due date._____ ☐ Nursing ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Hydrocodone/Oxycodone

Other? ☐ Y ☐ N If yes: _____

Do you use controlled substances? ☐ Y ☐ N If yes: _____

Check whether the patient has had any of the following:

☐ AIDS/HIV Positive	☐ COPD	☐ Jaw Pain	☐ Shingles
☐ Anaphylaxis	☐ Diabetes	☐ Kidney disease	☐ Shortness of breath
☐ Anemia	☐ Epilepsy	☐ Liver Disease	☐ Skin rash
☐ Arthritis, Rheumatism	☐ Fainting	☐ Leukemia	☐ Spina bifida
☐ Artificial heart valves	☐ Food allergy	☐ Mitral Valve Prolapse	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Nervous system	☐ Surgical implant
☐ Atopic (allergy prone)	☐ Headaches	☐ Pacemaker	☐ Swelling of ankles
☐ Back problems	☐ Heart murmur	☐ Psychiatric care	☐ Thyroid disease
☐ Blood disease	☐ Heart problems	☐ Radiation treatment	☐ Tonsillitis
☐ Cancer	Describe_____	☐ Rapid weight gain/loss	☐ Tuberculosis
☐ Chemical dependency	☐ Hemophilia/Abnormal	☐ Respiratory disease	☐ Ulcer/Colitis
☐ Chemotherapy	bleeding	☐ Rheumatic/Scarlet fever	☐ Venereal disease
☐ Circulatory problems	☐ Cortisone treatments	☐ Herpes/Cold Sores	☐ Hepatitis

Other/Comments:

Authorization

- I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist/hygienist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist/hygienist.
- I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

HIPAA Form

RECORDS RELEASE

Records will be released to doctors we have referred you to at no charge; however, if you are requesting your records be transferred to another dentist for any other purpose, there may be a $35 charge. You will also need to sign a records release form. These forms are available through us or another dental provider. Initials _____

PRIVACY PRACTICES

Open and Affordable Dental Notice of Privacy Practices is posted in the office waiting room and on our website. Hard copies are also available for all patients. In accordance with the HIPAA Privacy act, all patients are required to acknowledge receipt of the Notice of Privacy Policies.

Initials _____

ACKNOWLEDGEMENT

By signing this form, I acknowledge receipt of Open and Affordable Dental Office Policies and Notice of Privacy Practices. I understand that the Notice of Privacy Practices contains information on the uses and disclosures of any personal health information, and I have been given the opportunity to review the Notice. I understand that the terms of the Notice may change and that I will be given a revised notice if changes occur. I understand that I may request restrictions on the uses and disclosures of information for the purpose of treatment, payment, or dental care operations. I understand that Open and Affordable Dental is not required to agree to such requests, but that if they do agree, those restrictions are binding on Open and Affordable Dental.

Initials _____

CONSENT

I authorize Open and Affordable dentists and hygienists to examine, take radiographs, study models, photographs, and/or any other diagnostic aids deemed appropriate and necessary, and perform treatment and therapy that may be indicated in connection with my (or my child's) dental care. I also understand that the use of anesthetic agents embodies certain medical risks. Initials _____

SCHEDULING

I authorize Open and Affordable Dental to leave a voicemail, send an email, and/or send a text message to the phone/email provided on the New Patient Form for the purpose of appointment scheduling and reminders. Initials _____

AGREEMENT TO PAY FOR TREATMENT

I understand that I am responsible for payment of all dental services provided in this office (whether or not insurance or third party payer is involved) and that payment is due at the time services are rendered. If I do not pay the entire balance, or if insurance is unpaid after 60 days, a billing charge, or interest will be added to my account. The billing charge will accrue at the rate of 1.5% per month, which is an annual percentage rate of 18% (or a minimum charge of $5.00). In case of default of payment, I agree to pay any and all costs in collecting this account, including but not limited to reasonable attorney's fees and court costs. I also understand the office policy is to require a minimum of one business day notice for all cancelled/rescheduled appointments. If this is not possible, a fee of $40.00 that is not reimbursable by insurance may be charged to my account.

_____ _____

Patient/Guardian's Signature Date

INSURANCE

As a courtesy to our patients, we will prepare and submit your insurance forms for reimbursement. We cannot obtain payment, however unless you provide us with all of the necessary information as requested above. Additionally, please understand that your insurance is a contract between you/your employer and the insurance company. We cannot in any way guarantee benefits or payment from your carrier, nor can we know the specifics of every individual plan. It is your responsibility to know the terms and limitations of your insurance plan.

Please read and understand that by signing, you are agreeing to the following

- I authorize my insurance to pay the doctor directly all insurance benefits otherwise payable to me.
- I authorize the doctor to release any information including, but not limited to, records of treatment, or examination, person identification, x-rays, medical history, etc. to my insurance company as requested.
- Any estimates given with regard to treatment fees are only rough estimates based on limited information we have about your plan.

_____ _____

Patient/Guardian's Signature Date