WELCOME TO PEARL FAMILY DENTISTRY!

We thank you for choosing us as your dental care provider and appreciate the confidence you place with us to provide dental services. To assist us in better serving you, please complete the following form. The information provided on this form is important to your dental care at our practice. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT INFORMATION

Patient's Name: (Last) _____(First)_____(MI)_____

Date of birth: _____ Social Security#_____ Driver's License #_____

Sex: _____ Marital Status: ____Minor ____Single ____Married ____Separated ____Divorced ____Widowed

Home address:_____

City: _____ State: _____ Zip: _____Home Phone:_____

Cell Phone: _____Work Phone: _____Ext- _____

Email: _____

Emergency Contact Name and #_____

Employer: _____ Occupation: _____

Spouse /Parent's Name: _____ Contact #_____

If patient is a student: Name of School/College_____City&State_____

Are any of your family members our patients? (Yes/No)_____If Yes, Who?_____

How did you hear about us? Please tell us: _____

Previous Dentist's Name and Phone No.: _____

Last Dental Visit (Date): _____

PRIMARY DENTAL INSURANCE

Name of Insurance Co.: _____ Phone No.: _____

Subscriber's name: _____ Date of Birth: _____ Relationship:_____

Employer's Name: _____Social Security#_____Subscriber ID#_____

Employer's Address: _____Group/Contract/ Local #: _____

SECONDARY DENTAL INSURANCE

Name of Insurance Co.: _____ Phone No.: _____

Subscriber's name: _____ Date of Birth: _____ Relationship:_____

Employer's Name: _____Social Security#_____Subscriber ID#_____

Employer's Address: _____Group/Contract/ Local #: _____

Please continue on next page

CO-PAYMENTS

To accept insurance, we now debit co-payments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check:

Card Type: _____Card #_____

Name on Card: _____ Exp. Date: _____

AUTHORIZATION:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I understand that I am responsible for all changes whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary.

I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested. I understand that check payments may be converted to automatic bank drafts. I have reviewed the information on this form, and is accurate to the best of my knowledge.

X_____Date:_____

Signature of Patient, Parent or responsible party

DENTAL HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Reason for seeking care today: ____Exam ____Professional Cleaning ____Specific problem _____

Please check/answer all that apply:

___ Are you having pain/discomfort at this time? ___Have you ever had full mouth x-rays taken? If yes, when? _____

___Have you ever had treatments for your gums? ___Do your gums hurt or bleed when you brush?

___Do your teeth hurt when you chew? ___Have you ever had orthodontic treatment or worn braces?

___Are your teeth sensitive to hot, cold, sweet? ___Have you ever been aware of a bad odor or taste in your mouth?

___Are you on a special diet? ___Do you clench or grind your teeth during day or night?

___Do you jaw joint pain or jaws feel tired? ___Do you mouth breathe or difficulty breathing through nose?

Would you like whiter teeth? _____

Is there anything that bothers you about the appearance of your teeth or smile?_____

Would you like to have straighter teeth? _____

Please rate how anxious are you about dental treatment? (1-totally relaxed, 10- highly anxious) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

Why did you leave your previous dentist?_____

Did your parents have difficulties with their teeth or dental treatment?_____

MEDICAL HEALTH HISTORY:

Physicians Name:_____ City: _____ Phone: _____
Are you see a physician now or planning to see one for any reason? Please explain _____
Have you been hospitalized for any reason? Please describe_____
Do you use tobacco products? What and how much _____
Do you use alcoholic beverages? How much_____
Do you use recreational drugs? What and how much_____

For women only
____Are you now or think you may be pregnant?
____Are you nursing?
____Are you presently taking birth control pills?

Check any of the following you have had or have at present:

____Anemia	____Angina, Chest Pain	____Arthritis
____Artificial Joints	____Artificial Heart Valve	____ Asthma
____Blood Thinners (e.g. Coumadin)	____Bleeding Problems	____Cancer or Tumors
____Chemotherapy	____Congenital Heart Defects	____Drug Addiction
____Diabetes	____Emphysema	____Epilepsy/Seizures
____Glaucoma	____HIV/AIDS	____Heart Disease or Attack
____Heart Surgery	____Herpes	____High Blood Pressure
____Hepatitis A	____Hepatitis B	____Hemophilia
____Kidney Problems	____Liver Problems	____Low Blood Pressure
____Lung Disease	____Multiple Sclerosis	____Pacemaker
____Psychiatric Disease	____Rheumatic Fever/Rheumatism	____Radiation Treatment
____Sinus Trouble	____Sickle Cell Disease	____Stroke
____Thyroid Disease	____Tuberculosis (TB)	____Venereal Disease / STDs

List any other conditions not listed above: _____

Are you taking any medications, drug or pills? If yes, please list

Medication Name	**Dosage/Frequency**	**Condition**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic or have reacted adversely to any of the following medications?

____Aspirin, Acetaminophen, Ibuprofen	____Codeine, Demerol or other narcotics	____Sulfa Drugs
____Local anesthetics ("Novocaine")	____Penicillin or other antibiotics	____Latex
____Barbiturates, sedatives, etc	____Reaction to metals	____Nitrous Oxide

Others, please list_____

Please indicate if you would prefer to speak privately with the dentist about a medical issue? ____Yes ____ No

I will inform this office of any change in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, jaw necrosis, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

X_____Date: _____
Signature of Patient, Parent or responsible party

DENTAL OFFICE INFORMED CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is a risk associated with dental procedures, and all your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like "filling" can lead to major complications that cannot be foreseen. For example, "Novacaine" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments. The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding. infection, and other nerve problems.

I have read, understand and consent to dental treatments. INITIALS: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

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
____Communication barriers prohibited obtaining the acknowledgement
____An emergency situation prevented us from obtaining acknowledgement
____Other (please specify)

OFFICE POLICY

When we make your appointment, we are reserving a room for your particular needs. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We ask that if you must change an appointment, please give us at least 48 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it. **We reserve the right to charge for any appointment(s) broken without a 48 hours notice. The charge will be $50.00 for every thirty minutes of appointment time.** ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.*** We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Checks returned from the bank is subject to $ 35.00 service fee. Accounts delinquent more than 60 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. We agree in writing with every patient to sign our financial policy, as we have found with our past experience that this policy makes our mutual experience easier and without confusion. This policy is to ensure that all of our patients receive a highest level of quality dental care in a friendly and healthy environment while understanding their financial responsibilities. This policy as well as other health and insurance forms provided must be read, agreed to, and signed prior to any dental treatment.

Cash Patients
Patients with no insurance are expected to pay in cash, check or credit card the day the service is rendered, unless specific arrangements are made in advance.

Insurance Patients
For those patients covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% of the cost of your treatment. In this day and age many cover 50% or less on many services and actually cover nothing on others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a pre -determination to their insurance carriers. We state what treatment you need, and they tell us what they will cover on that treatment plan. Many patients prefer to get service started immediately, and some treatments should be started immediately. In these cases, we will ask you to pay for your services in full as they are done, and when the insurance company pays their portion we will reimburse you for what they pay. We will assist you in dealing with the insurance company, but ultimately the responsibility of payment and insurance problems lies with you. If we do accept assignment of benefits from the insurance company, if the insurance company hasn't paid after 45 days, the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot he treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. Thank you for reading and understanding our financial policy. If you have any questions or concerns; please feel free to ask them at any time. We wish to be of assistance in any way we can.

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED CONSENT, OFFICE POLICIES AND FINANCIAL POLICIES.

_____ Date: _____
Signature of responsible party

_____
Please print your name