# Please take your time to fill out all 3 pages

# Patient Information Dental Insurance (if you have provided your insurance info then you can skip this portion.)

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder (Insured) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to policy holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact **­­­­­­­­Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone Number ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to Dr. Joseph all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information the above-named Insurance Company and their agents for the purpose of benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand

it is my responsibility to notify the dentist whenever I have a change of insurance.

Signature of Patient, Parent, or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name as Above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Electronic Communication

I have read the consent form for electronic communication. I hereby authorize for the dental practice to use my email information to communicate with me electronically.

Signature of Patient, Parent, or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental History

Date Of Last Dental Cleaning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clicking Or Popping Jaw: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Of Last Dental X-Rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grinding Teeth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Orthodontic Treatment, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sensitivity To Hot Or Cold: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Periodontal Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Numbness in mouth: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cigarette, Or Cigar Smoking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Health History

PHYSICIAN’S NAME/phone/Fax/ DATE OF LAST VISIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR WOMEN: PREGNANT? Yes or No 1st /2nd /3rd trimester Due date: \_\_\_\_\_\_\_\_\_\_

BREAST FEEDING? Yes or No CONTRACEPTIVE (Birth Control)? Yes or No ASA: I, II, III, IV (Office only)

#### PLEASE CIRCLE “YES” OR “NO (past)” TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING: \* medical clearance form possibly required, if condition(s) is current.

AIDS/HIV\* YES OR NO HEART MURMUR\* YES OR NO -> if YES: FUNCTIONAL OR

ASTHMA YES OR NO JAUNDICE YES OR NO NON-FUNCTIONAL

ANEMIA YES OR NO JAW PAIN YES OR NO

ARTHRITIS YES OR NO KIDNEY DISEASE\* YES OR NO

ARTIFICIAL HEART VALVES\* YES OR NO LIVER DISEASE\* YES OR NO

ARTIFICIAL JOINTS\* YES OR NO MITRAL VALVE PROLAPSE\* YES OR NO -> if YES: FUNCTIONAL OR

BLOOD DISEASE YES OR NO PACEMAKER\* YES OR NO NON-FUNCTIONAL

BACK PROBLEMS YES OR NO PSYCHIATRIC CARE YES OR NO

BLEEDING ABNORMALLY\* YES OR NO RESPIRATORY DISEASE YES OR NO

CIRCULATORY PROBLEMS YES OR NO RHEUMATISM YES OR NO

CHEMICAL DEPENDENCY YES OR NO RHEUMATIC FEVER\* YES OR NO

COUGH, PERSISTENT\* YES OR NO STROKE\* YES OR NO

CANCER\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES OR NO SINUS TROUBLE YES OR NO

DIABETES Type:\_\_\_\_ YES OR NO SPECIAL DIET YES OR NO

EPILEPSY\* YES OR NO SCARLET FEVER\* YES OR NO

EMPHYSEMA\* YES OR NO STEROID (CORTISONE Treatmt\*YES OR NO

EDEMA, SWELLING YES OR NO SKIN RASH YES OR NO

FAINTING (vertigo) YES OR NO SHORTNESS OF BREATH (CHF\*) YES OR NO

GLAUCOMA\* YES OR NO SWOLLEN NECK GLANDS YES OR NO

LOW BLOOD PRESSURE YES OR NO TUBERCULOSIS\* YES OR NO

HIGH BLOOD PRESSURE YES OR NO TONSILITIS YES OR NO

HEADACHES YES OR NO THYROID PROBLEMS YES OR NO

HEART PROBLEMS\* YES OR NO TUMOR GROWTH\* YES OR NO

HEPATITIS TYPE\*\_\_\_\_\_\_\_\_ YES OR NO VENEREAL DISEASE YES OR NO

HERPES\* YES OR NO WEIGHT LOSS YES OR NO

Please list any **surgery** you have had in the past and date of operation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any **prosthesis** (ex. stents, metal screws/plates)? **YES OR NO**, IF YES, DATE OF INSERTION: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has your doctor recommended **premedication**, prior to dental appointment? **Y or N**, if YES, What **Anti-biotic**:\_\_\_\_\_\_\_\_\_

**MEDICATION: Yes/No**

LIST ANY **MEDICATION** YOU ARE CURRENTLY TAKING AND THE CORRELATING **DIAGNOSIS**:

1) MED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIAG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) MED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIAG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) MED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIAG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) MED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIAG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) MED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIAG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) MED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIAG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking or have you ever taken **Bisphosphonates**?(ex. Fosomax, Actonel, Humira etc.) For osteoporosis, chemotherapy etc.? **:□Yes □No**

# ALLERGIES PLEASE CIRCLE “YES” OR “NO” IF YOU ARE ALLERGIC TO:

ASPIRIN YES OR NO CODEINE YES OR NO PENICILLIN YES OR NO SULFA YES OR NO

IODINE YES OR NO LATEX YES OR NO LOCAL ANESTHETIC YES OR NO

PLEASE LIST ANY OTHER DRUGS YOU ARE **ALLERGIC** TO: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Consent**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize River Trails Dentistry to use and disclose my protected health information to carry out:

• Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

• Obtaining payment from third party payers (e.g. my insurance company);

• The day-to-day healthcare operations of River Trails Dentistry

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that River Trails Dentistry reserves the right to change the terms of this notice from time to time and that I may contact River Trails Dentistry at any time to obtain the more current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out the treatment, payment, and health care operations, by River Trails Dentistry (which is then bound to comply with this restriction).

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

**Payment Policy**

To avoid any misunderstandings regarding insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees at the time of service. Our patients may use cash, credit card, or care credit to pay their balances. **We do not accept checks and we will collect patient’s responsibility prior to procedure. We do not render our service on the basis of what our patient's insurance companies will or will not cover**. We render our services based on our patients' oral health and the best treatment to maintain and/or restore our patients' oral health.

The portion that is charged to our patient is the **estimated** amount due from the patient based on what the insurance company has conveyed over the telephone to our office staff. However, if the insurance company does not cover all of the fees, **the patient is responsible for any and all balances remaining**. We will file the primary insurance as a courtesy; however, the patient is responsible for all fees incurred. In addition to all other remedies, the patient shall pay River Trails Dentistry expenses and attorney's fees and/or any other outside collection agency fees incurred to collect money owed to River Trails Dentistry from the patient under these terms.

If you need to cancel or reschedule any appointments please allow a 24 hour advanced notice, so that we can accommodate other patients. **There will be a $50 charge to your account for any no show or cancelled appointment without a 24 hour notice.**

*(When patients are requesting copies/mail of any documentation or x-rays there will be $5.00 charge for each service. For special cash exam/xray(s) will be $25.*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_