COBBLESTONE PARK
FAMILY DENTAL

GETTING TO KNOW YOU

PATIENT NAME _____ SOCIAL SECURITY NUMBER _____-_____-_____ DOB _____/_____/_____

HOME ADDRESS _____ CITY, STATE, ZIP _____

PRIMARY PHONE (_____) _____ - _____ SECONDARY PHONE (_____) _____ - _____ EMAIL _____

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] CHILD DRIVERS LICENSE AND STATE _____

[ ] DIVORCED [ ] SEPARATED [ ] WIDOWED

PRIMARY INSURANCE COMPANY _____ GROUP # _____ SUBSCRIBER # _____

SECONDARY INSURANCE COMPANY _____ GROUP # _____ SUBSCRIBER # _____

Please note: Providing the above contact information (address, phone numbers, and email address) gives Cobblestone Park Family Dental permission to contact you using the media indicated concerning appointments, newsletters and other business matters. We will not share your contact information.

RESPONSIBLE PARTY _____ SOCIAL SECURITY NUMBER _____-_____-_____ DOB _____/_____/_____

HOME ADDRESS _____ CITY, STATE, ZIP _____

PRIMARY PHONE (_____) _____ - _____ SECONDARY PHONE (_____) _____ - _____ EMAIL _____

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] CHILD DRIVERS LICENSE AND STATE _____

[ ] DIVORCED [ ] SEPARATED [ ] WIDOWED RELATIONSHIP TO PATIENT _____

RESPONSIBLE PARTY EMPLOYER _____ OCCUPATION _____ WORK PHONE (_____) _____ - _____

BUSINESS ADDRESS _____ CITY, STATE, ZIP _____

SPOUSE'S NAME _____ SOCIAL SECURITY NUMBER _____-_____-_____ DOB _____/_____/_____

HOME ADDRESS _____ CITY, STATE, ZIP _____

PRIMARY PHONE (_____) _____ - _____ SECONDARY PHONE (_____) _____ - _____ EMAIL _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____ WORK PHONE (_____) _____ - _____

BUSINESS ADDRESS _____ CITY, STATE, ZIP _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (please only check one)

Who selected this office? [ ] SELF [ ] SPOUSE [ ] PARENT [ ] EMPLOYER

Where did you find the phone number to this office? REFERRED BY A [ ] FRIEND OR [ ] RELATIVE [ ] INSURANCE PLAN [ ] DIRECT MAILING [ ] SIGN BY BUILDING [ ] OTHER _____

*If referred, whom may we thank for referring you? _____

CONSENT

I will answer all health questions to the best of my knowledge _____ (Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out the procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____ Date _____ Relationship to patient _____

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MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Scarlet Fever	☐	☐
Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	HPV (Human Papilloma Virus)	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
Angina (Chest pain)	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Stomach Problems	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Stroke	☐	☐
Artificial Heart Valve	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Thyroid Disease	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers	☐	☐
Blood Disease	☐	☐	Heart Lesions (Congenital)	☐	☐	Nervousness/Depression	☐	☐	Venereal Diseases	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Other _____		
Cancer	☐	☐	Heart Surgery	☐	☐	Pregnant Currently	☐	☐	_____		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Radiation (head/neck)	☐	☐	_____		
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Respiratory Problems	☐	☐	_____		
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Rheumatic Fever	☐	☐	_____		
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐	_____		

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

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Percodan	☐	☐	Tetracycline	☐	☐	Valium	☐	☐
Darvon	☐	☐	Latex	☐	☐	Codeine	☐	☐	Penicillin	☐	☐
Nitrous Oxide	☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐

Other _____
_____
_____

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosomax	☐	☐	Herbal Supplements	☐	☐
Reclast	☐	☐			

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

Family Physician Phone Number

_____

Do you smoke or use tobacco products?

How much?_____

For how long?_____

Please share the following dates:

-last cleaning_____ -last dental exam_____ -last complete x-rays_____

CONSENT

I will answer all health questions to the best of my knowledge _____ (initial)

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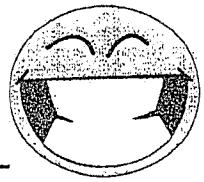
Signature _____ Date _____ Relationship to patient _____



Getting to know your smile!

NAME _____ DATE _____

1. What are you hoping to accomplish during your appointment today? _____

_____

2. Have you had an experience that left you unhappy with any previous dental care? If yes, please explain. _____

_____

3. Where would rate your current dental health on a scale from 1-10? _____

4. Are you noticing any sensitivity to cold, hot, sweets or pressure or biting? _____

_____

5. What would you change about your smile if you could? _____

_____

6. Are you happy with the color of your teeth? _____

_____

7. Have you ever had a sleep study completed? _____

_____

8. Do you experience ringing in your ears, headaches or jaw joint pain? _____

_____

9. Do you have a history of periodontal treatments?

_____

10. Do you have any missing teeth? _____ If yes, how long have they been missing? _____

Are you interested in replacing the missing teeth? _____

11. Do you currently wear any partials or dentures? _____ If yes, how old are they? _____

12. Do you have any crowns or bridges? _____ If yes, how old are they? _____

13. How did you hear about us? _____

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FINANCIAL TERMS AND CONDITIONS

This office depends on the reimbursement from the patient for the costs incurred in their cases. The financial responsibility of each patient must be determined before treatment begins as a condition for treatment by this office. Financial arrangements must be made in advance. All emergency dental services, or any dental service preformed without prior financial arrangements, must be made at the time of service.

If I carry insurance, I understand that this office will prepare my insurance forms, assist in making collections from the insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumptions that charges will be paid by an insurance company. Benefits and eligibility will be verified and discussed prior to treatment. In the event the insurance under or over pays, I understand that I am responsible for the remaining balance or can expect a refund.

_____ I understand that all dental services furnished to me are my financial responsibility.

_____ I understand not all services are a covered benefit. Benefits vary due to policy and insurance provider.

_____ It is patient responsibility to verify their own insurance coverage.

_____ Fees for non-covered services, deductibles, and co-payments are DUE at the time of treatment.

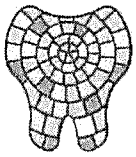
_____ We file your insurance as a courtesy to you, but ultimately you are responsible for any charges incurred at the time of service.

_____ Insurance companies do not provide us with complete access of payment rules; therefore, any quote of out-of-pocket fees you are presented with today, is ONLY an estimate.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this office accruing to me under my contract. I understand that the fee estimate listed for this dental are can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you. I grant my permission to you, or your assignee, to telephone me at home or at my place of employment to discuss matters related to this form.

I have read the above conditions and agree to their content.

Signature:_____ Date:_____



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Cancellation/Missed Appointment Policy

Patient Initials: _____

There will be a $25.00 fee for missed appointments, or appointments cancelled after the 24 hour cancellation/change appointment window expires.

If you miss your scheduled appointment once, you will be required to pay a downpayment prior to rescheduling your missed appointment.

Appointment Reservation

Patient Initials: _____

We require an appointment reservation of your **deductible** (if applicable) plus **10%** of patient estimated total upon booking any and all procedures. Appoinment reservation will be applied to the total procedure cost and is refundable if 24 hour notice is given prior to scheduled appointment.

We understand that unplanned issues do arrise, and respectfully ask that notice of 24 hours prior to your appointment is given to our office. Appointment Reservation will be applied to rescheduled appointment. By not rescheduling appointment, appointment reservation will be forfeited.

Our Doctors and Hygienists want to be available for your needs, and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.

Thank you for being a valued patient and for your understanding and cooperation as we implement these policies. These policies will help us open otherwise unused appointments to better serve the needs of all our patients.

Signature:_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

{Please Print Name}

_____

{Signature}

_____

{Date}

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____ authorize the following person (s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	{Relationship}
_____	_____
{Please Print Name}	{Relationship}
_____	_____
{Please Print Name}	{Relationship}

Please check if you would like a copy of Cobblestone Park Family Dental Notice of Privacy Practices [ ]

Emergency Contact: _____ _____

Name Phone Number