Hope
DENTAL PROFESSIONALS
Cosmetic & Family Dentistry

Demographics

Today's Date_____ **How did you hear about our office?** _____

Patient Name Mr. Ms._____ **Preferred Name** _____ **Date of Birth**_____

Address _____ **Apt #**_____ **City** _____ **State**_____ **Zip**_____

Phone (H) _____ **(Work)** _____ **ext**_____ **(Cell)** _____

Best Time / Place to reach you_____ **E-Mail Address** _____

Social Security _____ **Gender: M or F** **Are You (circle one): Single Married Divorced**

Place of Employment_____ **Occupation**_____

Insurance Information:

Name of Ins. Co. _____ **Policy/Member ID**_____

Name of the Policy Holder _____ **Social Security of Policy Holder**_____
Relation to Policy Holder: (Circle one) Self, Spouse, Dependent **Date of Birth of Policy Holder**_____

Secondary Insurance Policy: Name of Ins. Co. _____ **Policy/Member ID**_____

Name of the Policy Holder _____ **Social Security of Policy Holder**_____
Relation to Policy Holder: (Circle one) Self, Spouse, Dependent **Date of Birth of Policy Holder**_____

Spouse/Parent/Guardian Information:

Name Mr Ms._____ **Preferred Name** _____ **Date of Birth**_____

Address _____ **Apt #**_____ **City** _____ **State**_____ **Zip**_____

Phone (H) _____ **(Work)** _____ **ext**_____ **(Cell)** _____

Best Time / Place to reach you_____ **E-Mail Address** _____

Social Security _____ **Gender: M or F** **Are You (circle one): Single Married Divorced**
Place of Employment_____ **Occupation**_____

Emergency Contact Information: (Person not living at your residence.)

Name Mr Ms._____ **Relationship to patient**_____ **Phone (H)** _____

Address _____ **Apt #**_____ **City** _____ **State**_____ **Zip** _____

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Medical History

Patient Name_____ Date of Birth_____

Name of Physician_____**Last physical** _____

1. **Are you in good health? Yes□ No□** _____
2. **Do you smoke/use smokeless tobacco Yes□ No□ How much?** _____
3. **Do you drink alcohol? Yes□ No□ How often?** _____
4. **Do you currently or have you ever used illegal drugs or have a chemical dependency Yes□ No□**
5. **Are you currently under the care of a physician? Yes□ No□**_____
6. **Have you been hospitalized or had a major operation? Yes□ No□** _____
7. **Have you ever had a serious neck or head injury? Yes □ No □** _____

8 Do you require an antibiotic prior to treatment? Yes□ No□ _____

9. Have you ever taken Phen-Fen/ Redux? Yes□ No□ Bone Density medication? Yes□ No□

10. Do you take an Aspirin every day? Yes□ No□

11. Women only: Are you pregnant/nursing? Yes□ No□ Are you taking oral contraceptives? Yes□ No□

Are you allergic to any of the following?

□Aspirin □Penicillin □Codeine □Metal □Latex □Local anesthetics □Sulfa □Other_____

_____

Do you have or have a history of the following?

□AIDS/HIV positive	□Fainting or dizziness	□Rheumatic fever
□Anemia/Blood disorder	□Glaucoma	□Scarlet fever
□Arthritis/Gout	□Headaches	□Sinus trouble
□Artificial Heart valves/joints	□Heart murmur	□Skin rash
□Asthma	□Hepatitis Type_____	□Special diet
□Back problems	□High/Low blood pressure	□Stroke
□Bleeding problems/disease	□High cholesterol	□Swollen feet or ankles
□Cancer	□Kidney disease	□Swollen neck glands
□Chemotherapy	□Liver disease	□Thyroid problems
□Circulatory problems	□Mitral valve prolapse	□Tonsillitis
□Cold sores/fever blisters	□Osteoporosis	□Tuberculosis
□Cortisone treatment	□Pacemaker	□Tumor or growths
□Diabetes	□Psychiatric/Nervous Problems	□Ulcers--stomach
□Emphysema	□Radiation treatment	
□Epilepsy/convulsions	□Respiratory disease (breathing troubles)	

Medications you are currently taking, including over the counter and vitamins: Please write on the back if you need more space:

_____ _____**mg How often**_____
_____ _____**mg How often**_____
_____ _____**mg How often**_____
_____ _____**mg How often**_____
_____ _____**mg How often**_____

Patient Signature_____Date_____

Doctor/Hygienist
Signature_____Date_____

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Dental History

Patient

Name_____ Date of Birth_____

Previous Dentist Name _____**Address**_____
Phone _____

Last visit _____ **Reason for that visit** _____
How often do you get your teeth cleaned? _____

Please answer the following questions (Circle the answer):

1. **Do your gums bleed**.....**Yes No**
2. **Do you have bad breath**.....**Yes No**
3. **Do you experience sensitivity to cold, hot, sweets, or pressure**.....**Yes No**
4. **Do you have sore teeth**.....**Yes No**
5. **Do you have a bad taste in your mouth**.....**Yes No**
6. **Do you have periodontal disease / treatment**.....**Yes No**
7. **Do you a burning sensation in your mouth**.....**Yes No**
8. **Do you have difficulty swallowing**.....**Yes No**
9. **Do you have popping or clicking in your jaw**.....**Yes No**
10. **Do you have dry mouth, throat or eyes**.....**Yes No**
11. **Do you have jaw problems**.....**Yes No**
12. **Do you clench or grind your teeth**.....**Yes No**
13. **Do you have missing any teeth**.....**Yes No**
14. **Are you unhappy with the appearance of your teeth**.....**Yes No**
15. **Have you used bleaching products**.....**Yes No**
16. **Did you have orthodontia (braces)**.....**Yes No**
17. **Does food collect between your teeth**.....**Yes No**
18. **Are you a mouth breather**.....**Yes No**
19. **Do you chew on one side of your mouth**.....**Yes No**
20. **Do you bite your fingernails**.....**Yes No**

How do you rate your current dental health? ____ **Excellent** ____ **Good** ____ **Fair** ____ **Poor**
How often do you brush? _____**Morning** _____ **Night** _____**After every meal** _____ **2x/day**
What kind of toothbrush do you use? ____ **Manual** ____ **Electric**
How often do you floss? _____ **Daily** _____ **Weekly** _____ **Occasionally** _____ **Never**

Health and Nutrition:
Do you_____ **Eat Breakfast** _____**Drink Coffee** _____**Drink soda–how many a day**
Exercise:_____ **Light**_____ **Moderate** _____ **Heavy**
Quality of Sleep _____ **Level of stress at work or home** _____

What are you looking to improve about your smile?_____
_____
Comments, concerns or other information pertinent to today's appointment? _____
_____
_____

Patient/ Guardian Signature _____**Date**_____

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Understanding Your Dental Benefit

At Hope Dental Professionals, we strive to give the highest quality service. A part of that service is to help you understand how your dental benefit works and estimate your part of the investment in your dental health.

It is important that you know that we are here to **partner with you** in understanding your dental benefit coverage to better help you maximize this benefit. In order to do this, we request you bring a copy of your **insurance card**, as well as the **Name, Date of Birth and Social Security Number of the policy holder**. We can contact your dental benefit company to determine the coverage you have. This will allow us to give you the best possible estimate and to better help us better understand what exclusions, co-pays, deductibles and restrictive clauses are in your plan.

Some of the dental benefit companies we deal with do not always give information regarding their fees, and all of them do not guarantee benefit quotes (even with a predetermination). Your dental benefit plan is an agreement between you and the dental benefit company not between our office and the dental benefit company, so they are not obligated to give our office any information. Also, there are no regulations as to how dental benefit companies determine reimbursement, resulting in wide fluctuation. **Because of these practices, our estimates of your portion owed are an estimate and not a final quote. As a service to you we allow a 60 day grace period for your dental benefit to pay before it becomes your responsibility.**

I have read the above information, understand and agree to the conditions of the content. I hereby authorize payment directly to the office of Hope Dental Professionals the dental benefit otherwise payable to me.

Patient/Signature_____Date_____

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Informed Consent

General Consent for Treatment

I understand that all dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- **Drug reactions and side affects**
- **Damage to adjacent teeth or fillings**
- **Post-operative infection**
- **Post-operative bleeding that might require treatment**
- **Delayed healing of an extraction site, (dry Socket) requiring additional care**
- **Sinus involvement during removal of upper molars which require additional treatment or surgical repair at a later date**
- **Involvement of nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas**
- **Bruising, swelling, sensitivity or pain**
- **Failure of a dental procedure requiring additional treatment**
- **Breakage of dental instruments inside the tooth canals making additional treatment necessary**
- **Complications during treatment requiring a referral to a specialist.**

I understand the recommended treatment for my condition(s), the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fees involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

I hereby authorize the staff of Hope Dental Professionals to administer such medications and perform such diagnostic, photographic (including X-Rays and study models) and therapeutic procedures as may be necessary for proper diagnosis and dental treatment.

Patient/Guardian Signature_____**Date**_____

Witness_____**Date**_____

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Appointment Agreement

At Hope Dental Professionals we are committed to partnering with you to give you the time and attention you deserve. Scheduling and attending your appointment is also a very important part of our relationship. Dr. Pate and the Hygienist set aside this time exclusively for you, so we ask that you commit to your appointment times.

We know life changes and sometimes appointments need to be rescheduled. In order to give you excellent care, **a minimum of 2 business days notice** IS required if you are unable to keep your scheduled appointment.

Because it is very difficult to recover Dr. Pate's time lost, any appointment changes **within 2 business days** are subject to a fee of $50 to reschedule that will be used toward future treatment.

Please plan to be a **few minutes early** for your appointment time so that we can give you all the services planned for that day. Any arrival of **15 minutes** after your scheduled time are subject to be rescheduled with a $50 holding fee to be used towards future treatment.

Because mutual trust is essential to our relationship and to your best health outcomes, please know that the cornerstone for this is your responsibility to attend your scheduled appointments. As a courtesy, we will attempt to send you a reminder. Thank you for your partnership.

I _____, agree that I will make a sincere effort to make appointments I can keep and understand the value of our partnership in my dental health care. I realize that delaying treatment can lead to further issues and that Hope Dental Professionals is committed to helping me attain and maintain my dental health.

Patient Signature_____**Date**_____

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HIPAA Privacy Policy

Privacy Is Important to Us

Acknowledgment of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Hope Dental Professionals. I hereby authorize, as indicated by my signature below, Hope Dental Professionals to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

□ You may contact me at my home telephone number _____
□ You may contact me on my mobile telephone number _____
□ You may contact me on my work telephone number _____
□ You may send me an email appointment information, new services and products at:
_____
□ Other:_____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Relationship: _____ Date __/__/____ **(circle):** added / removed
2. _____ Relationship: _____ Date __/__/____ **(circle):** added / removed
3. _____ Relationship: _____ Date __/__/____ **(circle):** added / removed
4. _____ Relationship: _____ Date __/__/____ **(circle):** added / removed

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgment
□ An emergency situation prevented us from obtaining the acknowledgment
□ Other (Please Specify) _____

Staff Person Initials _____

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Assignment of Benefits

In order to ease your financial obligation at the day of service, the Assignment of Benefits allows your insurance company to pay Hope Dental Professionals instead of sending the check to your home. This allows you to only pay your estimated co-pay on the date of services. Any balance remaining after insurance is paid will still be your obligation.

I hereby assign all dental benefits, to which I am entitled to Hope Dental Professionals. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Hope Dental Professionals (Tax ID-200035154) for dental services rendered to myself and/or my dependents regardless of my insurance benefits if any. I understand that I am responsible for any amount not covered by insurance

I have read the above information, understand and agree to the conditions of the content. I hereby authorize payment directly to the office of Hope Dental Professionals the dental benefit otherwise payable to me.

Patient/Signature_____Date_____

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Financial Agreement

As validated by my signature on the bottom of this form, I understand and agree that:

1. All patient balances are due immediately after treatment is rendered.
2. Should a balance accrue on the account a statement will be sent and payment is to be made, in full, within **30 days** of the date on the statement.
    a. If payment is not paid within 30 days interest will be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.
    b. Should this debt go beyond 90 days it will be sent to collections and any additional fees for the collection process will be added to the balance.
3. If a check is returned, a returned check fee will be applied and must be paid immediately from the patient for each check payment returned to us by your bank.
4. Dental insurance is a contract between the patient and the insurance provider. Running, submitting and following up on claims for payment from the insurance provider is a **courtesy provided by the Hope Dental Professionals**, not an obligation. Ultimately, the patient is responsible for any treatment that is unpaid by the insurance provider that remains outstanding 60 days past treatment. As such, until payment is received from my insurance provider, no patient payment is final.
5. Estimates are predictions based on information from and history with the insurance companies. Therefore, estimates are not a guarantee of insurance payments. Estimated fees are good for 90 days from presentation.
6. Estimates do not take into consideration any money that was billed toward the patient's financial maximum or treatment limits that may have been used at other dental/specialist clinics.
7. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. Hope Dental Professionals will make an effort to anticipate any changes in the treatment plan and advise the patient at that time. However, such events are unpredictable.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

_____	_____	_____
Printed Name	Signature	Date