PATIENT INFORMATION

DATE:_____

First Name:_____Last Name:_____Middle:_____

Street Address:_____City:_____State:_____ZIP:_____

Home Phone:_____Cell:_____Work:_____e-mail address_____

Date of Birth:_____/_____/_____ Sex: M F Height:_____Weight:_____SS#:_____

Are you in good health? YES NO Has there been any change in your health within the past year? YES NO

Date of last physical exam_____ Are you currently under the care of a Physician? YES NO

If yes, for what condition(s)_____ Emergency contact name and #_____

Name, address and phone # of Physician_____

List current medications including non-prescription_____

_____

Are you allergic to any medications? If so please list_____

Do you take antibiotic pre-medication for your dental appointments? YES NO

PLEASE CIRCLE ANY CONDITION THAT RELATES TO YOUR PAST OR PRESENT

Heart Murmur	Rheumatic Heart Disease	Damaged Heart Valves	Artificial Heart Valves
Hip Replacement	**Hip/Knee Replacement**	**Artificial Joint**	**Prosthetic or implant**
Heart Attack	Cardiac Stents	High Blood Pressure	Tumors
Angina	**Cancer *Type:*_____**	**Epilepsy**	**Low Blood Pressure**
Abnormal Bleeding	Ankle Swelling	Shortness of Breath	Inborn Heart Defects
Pacemaker	**Diabetes**	**Persistent Diarrhea**	**Recent Weight Loss**
Hepatitis or Liver Disease	Allergies	Sinus Trouble	Asthma
Fainting Spells	**AIDS or HIV**	**Thyroid Problems**	**Emphysema**
Arthritis	Stomach Ulcer	GERD or Reflux	Kidney Trouble
Tuberculosis	**STDs**	**Persistent Cough**	**Swollen Neck Glands**
Blood Disorder	Addictions	Stroke	Problems w/ Mental Health
Alcoholism	**Back Pain**	**Trouble Reclining**	**Problems w/ Immune System**
Trouble with Anesthetics	Mitral Valve Prolapse	Hearing or Visual Impairment	

Significant Facial Trauma **Other:**_____

Have you ever had a reaction to….

Anesthetics Penicillin Sulfa Drugs Barbiturates/Sedatives Aspirin

Iodine Codeine Antibiotics Latex Have you ever taken FOSAMAX or BONIVA? YES NO

Do you……

Smoke Chew Tobacco If Yes….For How long_____How many times per day_____

Are you…..

Pregnant Nursing Taking Birth Control pills Menopausal

Are you wearing…..Dentures Partial Dentures Dental Implant Braces Retainers Night-guard

Are you happy with the color of your teeth? YES NO

What is your chief dental complaint?_____

Do you have…..Broken teeth Bleeding Gums Missing Teeth Bad Breath Discolored Teeth Pain Sensiti

Swelling Dental phobias Frequent cavities History of Periodontal disease

Problems with previous dental treatment_____

***Patient's NAME*:**_____ ***Date of Birth*:**___/___/____
Today's Date__/__/__

Circle: Single/Married/Widowed/Separated/Civil union

Spouse or Closest Relative_____

Patient's Occupation_____

If Student, circle FT / PT School_____

Primary Dental Insurance Holder

Name_____***Address***_____

Date of Birth__/__/__ SS# _____Phone #_____

Employer_____

Employer Address_____

Dental Insurance Company_____ Plan Type Traditional/PPO/HMO/Other

Insurance ID #_____Group #_____

Dental Insurance Phone #_____ Claims Address_____

Other Insurance Holder

Name_____Address_____

Date of Birth__/__/__ SS# _____Phone #

Employer_____

Employer Address_____

Dental Insurance Company_____ Plan Type: Traditional/PPO/HMO/Other

Insurance ID #_____Group #_____

*Referred by*_____

If you are completing this form for another person, what is your name and relationship?_____

Who is responsible for this account? _____

Patient or responsible party's Email Address:_____

List those parties for whom you give permission to discuss your dental care and billing statements with our staff

Name_____Relationship_____Phone#_____
Name_____Relationship_____Phone #_____
Name_____Relationship_____Phone#_____

I have reviewed the above information for changes and have made any necessary corrections

Patient Name_____ Patient Signature_____ Date_____

PATIENT NAME**_____*****DATE*****_____**

I authorize the dentist to perform diagnostic procedures and treatment necessary for proper dental care and I understand that dental examinations are for addressing immediate problems and additional visits with treatment may be required. **INITIALS_____**

I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or part by my dental insurance carrier or dental benefits payer.

INITIALS_____

We are pleased to inform you that Ocean Family Dental is a HIPAA compliant dental office. We strive to comply with this patient privacy act to protect you and your rights. Should you have any questions about HIPAA or the ways in which your privacy is protected please feel free to ask the Dentist or any staff member. I have read the above and therefore I understand that HIPAA practices are used at Ocean Family Dental.

INITIALS_____

I authorize the release of any information concerning my (or my child's) health care, and dental treatment to my dental insurance carrier, coordinating dental professionals, and persons I have indicated as authorized parties for the purpose of evaluating and administering appropriate dental care and treatment and for the purpose of collecting payments for services rendered.

INITIALS_____

We are pleased to inform you that we are a mercury free office. We do not place silver amalgam type fillings and have not done so for many years. We only use state of the art mercury free composite restorations for teeth requiring fillings or bonding. Composite fillings are tooth colored and the preparation is more conservative allowing for the preservation of more natural tooth structure. Some insurance companies will allow benefits for the cost of an amalgam filling which could result in a higher co-payment for the patient. I have read the above and understand that I will be responsible for any fees not covered by my insurance carrier.

INITIALS_____

I have read and understand this entire questionnaire and I have answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in completion of this form.

SIGN_____DATE_____

OFFICE USE ONLY: copy of insurance card? Yes/ No

DENTIST REVIEW_____DATE_____

Patient Name: _____ Date:_____

Payment Options

PLEASE INDICATE HOW YOU PLAN TO PAY FOR YOUR TREATMENT BY CHECKING ALL THAT APPLY.

□CASH **□Check** **Payment in full** (cash or check) at time of treatment

There will be a $ 25.00 charge on all checks returned for insufficient funds.

□CREDIT CARD

□ CareCredit CareCredit offers a comprehensive range of options, and it only takes a few minutes to apply for CareCredit. CareCredit enables you to finance 100% of your dental care with NO money down, NO interest for up to 12 months, NO up-front costs, NO annual fees, and NO pre-payment penalties, in most cases. Care Credit can be used by the entire family for ongoing treatment without having to reapply. Call 206-842-3764 or go to CareCredit direct: **www.carecredit.com**

□Budget Plan (does not apply to extractions or emergency root canals)

In-office Three Month Budget Payment Plan - For treatment over $500.00 (for established patients).This includes a pre-arranged date for automatic credit card or debit card processing (we will keep your card number on file).
Complete the section below if you are choosing a 3 month in office budget plan

Credit card #_____ Expiration date_____

CVC code_____ Name on Card_____

Billing Address_____ Billing Zip code_____

I_____, authorize Ocean Family Dental to charge _____ monthly payments to my credit card as listed above. The first payment should be charged to my credit card on _____.

In the event that the credit card is declined a second charge attempt will be made within one week then the remaining balance will be due within 30 days.

Signature _____ Date_____

Dental Insurance

Dental Insurance or "Dental Assistance" as it should be called, is designed to help pay part of the cost of dental treatment. You should be aware that dental insurance is NOT designed to pay all of the cost of treatment, but rather to be a partial aid. As a courtesy to you, we will handle most of the paperwork involved with your insurance. Please feel free to call or come by any time if you have a question. Any difference after insurance payment is received will be billed or credited to your account. Please be aware that due to the vast variety of dental insurance companies and individual plans. It is impossible for us to know the details of every plan. It is important that you take time to review your dental benefits prior to your appointment. Most insurance companies have online member services or send a booklet to members by mail. Please bring a copy of your plan details, often called a "breakdown of benefits" with you to your appointment.

ACCOUNT BALANCES
Billing statements are mailed monthly. Any services that remain unpaid by your insurance after 60 days will become part of your balance and appear on your statement. Please contact your insurance carrier to determine the reason for non-payment.

Discount plans We participate with several discount plans. Discount plans are not dental insurance but they do offer discounted dental procedures. You can find most of these plans listed on the internet. Please ask the front desk for details about our in-office discount plan.