Welcome

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ (Last Name / First Name / Middle Initial) Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Business Email _____

Primary Insurance

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Business Phone _____

Subscriber Employed by _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides.

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

☐ Y ☐ N Bad breath ☐ Y ☐ N Food collection between teeth ☐ Y ☐ N Periodontal treatment ☐ Y ☐ N Sensitivity to sweets
☐ Y ☐ N Bleeding gums ☐ Y ☐ N Grinding or clenching teeth ☐ Y ☐ N Sensitivity to cold ☐ Y ☐ N Sensitivity when biting
☐ Y ☐ N Clicking or popping jaw ☐ Y ☐ N Loose teeth or broken fillings ☐ Y ☐ N Sensitivity to hot ☐ Y ☐ N Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____ Date of last visit _____

Have you had any serious illnesses or operations? ☐ Y ☐ N If yes, describe _____

Are you currently under physician care? ☐ Y ☐ N If yes, describe _____

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check Y for yes or N for no if you have or have not had any of the following:

☐ Y ☐ N AIDS/HIV Positive
☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Anemia
☐ Y ☐ N Arthritis, Rheumatism
☐ Y ☐ N Artificial heart valves
☐ Y ☐ N Artificial joints
☐ Y ☐ N Asthma
☐ Y ☐ N Atopic (allergy prone)
☐ Y ☐ N Back problems
☐ Y ☐ N Blood disease
☐ Y ☐ N Cancer
☐ Y ☐ N Chemical dependency
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Circulatory problems
☐ Y ☐ N Cortisone treatments
☐ Y ☐ N Cough, persistent
☐ Y ☐ N Cough up blood
☐ Y ☐ N Diabetes
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting
☐ Y ☐ N Food allergies
☐ Y ☐ N Glaucoma
☐ Y ☐ N Headaches
☐ Y ☐ N Heart murmur
☐ Y ☐ N Heart problems
Describe _____
☐ Y ☐ N Hemophilia/Abnormal bleeding
☐ Y ☐ N Herpes
☐ Y ☐ N Hepatitis
☐ Y ☐ N High blood pressure
☐ Y ☐ N Jaw pain
☐ Y ☐ N Kidney disease or malfunction
☐ Y ☐ N Liver disease
☐ Y ☐ N Material allergies (**latex**, wool, metal, chemicals)
☐ Y ☐ N Mitral valve prolapse
☐ Y ☐ N Nervous problems
☐ Y ☐ N Pacemaker/Heart surgery
☐ Y ☐ N Psychiatric care
☐ Y ☐ N Rapid weight gain or loss
☐ Y ☐ N Radiation treatment
☐ Y ☐ N Respiratory disease
☐ Y ☐ N Rheumatic fever
☐ Y ☐ N Scarlet fever
☐ Y ☐ N Shingles
☐ Y ☐ N Shortness of breath
☐ Y ☐ N Skin rash
☐ Y ☐ N Spina Bifida
☐ Y ☐ N Stroke
☐ Y ☐ N Surgical implant
☐ Y ☐ N Swelling of feet or ankles
☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Tobacco habit
☐ Y ☐ N Tonsillitis
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Venereal disease

List medications you are currently taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

OLD MARKET DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

Resident Name:
Resident Address:
Facility Name: Old Market Dental
Medical Record Name:
Date:

I have been offered and/or given a copy of Old Market Dental's Notice of Privacy Practices ("Notices"), which describes how my health information is used and shared. I understand that Old Market Dental has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Old Market Dental website at www.oldmarketdental.com

My signature below acknowledges that I have been provided and/or offered a copy of the Notice of Privacy Practices:

Patient Signature:

Personal Representative's Title (when applicable):

FOR FACILITY USE ONLY: Complete this section if unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason (i.e. patient chosing to pay cash-no disclosure), state the reason:

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the Acknowledgement:

Completed by:

Facility Representative Signature:
Facility Representative Printed (Typed) Signature:
Date:

OLD MARKET DENTAL

Financial Policy

Old Market Dental believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT: Copays are due at the time of service. We accept cash, check, debit cards, and any major credit card (Visa/Mastercard/Discover/American Express). If you do not carry insurance, or if your coverage is currently under a pre-existing clause, payment in full is expected at the time of your visit. We ask for a copy of an ID in an effort to protect your identity and dental benefits. Please do not be offended! Please feel free to ask about our fees prior to the appointment. We also offer Care Credit. They may be applied for online at www.carecredit.com or at our location.

2. INSURANCE: We are participating with several insurance plans. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for any fees in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurance company, we will refund any overpayment to you.

   If our dentists are not listed in your plans network, you may be responsible for partial or full payments. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurance carrier may send the payment directly to you and therefore, our charges for your care are due at the time of service. Due to the many different insurance products available to the public, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurance carrier's member benefits department about services and physicians before your appointment.

   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited to your specific insurance policy.

3. RETURNED CHECKS will incur a $25 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge.

4. ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charge first, except for the insurance, which are applied to the corresponding dates of service.

5. BROKEN APPOINTMENTS: If you need to change your appointment time, please give at least 24 hours advance notice. There may be a $35 broken appointment fee, at the discretion of the office.

6. METHODS OF CONTACT: You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide. Methods of contact may include, but are not limited to, using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

I have read and understand Old Market Dental financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice on an as needed basis.

Signature:_____ Date:_____

Printed Name of Patient:_____