

Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Sex: Male / Female (other) \_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adult Account Holder for this patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance Company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber/Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Social Security Number \_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient covered by additional insurance? Yes / No/ If yes, list information on back of this page in the order above

**Assignment and Release**

 I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party’s: insurance carriers, payers, labs and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice (if applicable), and to be applied directly to any outstanding balance on my account.

 I understand **that I am financially responsible for “any and all” outstanding balance for services** provided that are not fully covered by insurance, and that I willbe billed for this remaining balance. This consists of any treatment started and any fees incurred, including lab fees, even if I fail to complete, said treatment. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I understand the dental practice cannot be held responsible for any services not paid for and/or denied by my insurance company as we are not party to the insurance contract held between you and your insurance company. **I agree to pay all estimated out of pocket expenses on the day of service.**

I have read and understand the above. Any questions I had about this form have been answered and I understand the answer. I attest to the accuracy of the information contained on this page.

Signature of Patient/Guardian/Personal Rep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient/Guardian/ Personal Rep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_ Todays Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
|  **Medical History**Are you now under the care of a physician? Yes / No If yes, Physicians name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If so, for what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Primary Physician's Name \_\_\_\_\_\_\_\_\_\_\_\_\_phone \_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
| Any serious illness, operation or hospitalization in the past 5 Years? Yes/No. If yes, what for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DENTAL HISTORY:**

|  |  |
| --- | --- |
| Former Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Dental visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**HEALTH HISTORY:** Circle Yes/No to indicate if you have/had, any of the following: |  |
|  |  |  |  |  |
| Liver Disease Yes/No Psychiatric Problems (List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Yes/NoSores/Blisters on lips or in mouth: Yes/No Dry Mouth Yes/NoEar Pain Yes/No Previous Orthodontic Treatment: Yes/No Jaw Pain Yes/No Clenching/ Grinding Yes/NoPrevious Periodontal Treatment Yes/No Jaw Clicking/popping Yes/NoUse smokeless Tobacco Yes/No Use Cigars/Pipe/Cigarettes Yes/NoAbnormal Bleeding Yes/No Arthritis/Rheumatism Yes/NoAspirin Therapy Yes/No Asthma or other lung disease Yes/NoAlcohol Abuse Yes/No Alzheimer’s/Dementia Yes/NoBleeding disorders Yes/No Cancer (Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Yes/NoChemical Dependency Yes/No Diabetic (Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Yes/NoEpilepsy/Seizures, Convulsions Yes/No Fainting/Dizziness Yes/NoFrequent Headaches Yes/No HIV+ or AIDS Yes/NoHepatitis A B C (circle one) Yes/No High Blood Pressure Yes/NoLow Blood Pressure Yes/No Joint Replacements Yes/NoPins, plates, rods or screws Yes/No Kidney Problems Yes/NoRadiation Treatment/Therapy Yes/No STD’s Yes/NoSinus Trouble Yes/No Thyroid Disease Yes/NoCongenital Heart Disease Yes/No Cardiovascular (heart attack, surgery, Angina…) Yes/NoArtificial Heart Valve, Pacemaker or stents Yes/No Stroke Yes/NoName\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  **MEDICATIONS:** |  |  |  |  |  |
|  Are you taking any medicine(s), diet pills, non-prescription, Vitamins and or supplements, homeopathic or natural  Remedies? List here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  (Please attach a separate list of medications if needed)

|  |  |  |
| --- | --- | --- |
| **ALLERGIES:** |  |  |
| Are you allergic to or had a reaction to? |
|  |  |  |  |
| Local Anesthetics Yes / No Barbiturates (sleeping pills) Yes / No |
|  |
| Iodine Yes / No Metals Yes / NoLatex Yes / No Tetracycline Yes / NoAspirin Yes / No Penicillin Family Yes / NoCodeine Yes / No Sulfa Drugs Yes / NoErythromycin Yes / No Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **FOR WOMAN ONLY:**Are you pregnant or is there any chance you MAY be pregnant Yes / NoAre you Nursing Yes / NoAre you using Oral Contraceptives Yes / NoPlease list any other health related conditions, diseases Or health problems that you think we should be aware of I understand the importance of a **truthful and complete health history to assist my dentist in providing the best care possible and I have filled this out to the best of my ability.**Signature of Patient or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name of Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Use Only: Assistant’s Initials \_\_\_\_\_\_ Front Desk Initials \_\_\_\_\_\_\_C:\Users\l2\Desktop\NVD Logo - Purple (2).jpg**Financial Policy**I understand that I am financially responsible for any charges incurred by me from this office. If there are any outstanding balances for services provided that are not fully covered by insurance, I understand that I will be billed for this remaining balance and I will pay this balance within 30 days. I also understand that any remaining balance of over $50 on my account that is not paid in that 30 days, disallows me or my family to be seen for any dental treatment in the office, until that balance is paid in full. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I understand the dental practice cannot be held responsible for any services not paid for and/or denied by my insurance company as we are not party to the insurance contract held between you and your insurance company. I agree to pay all estimated out of pocket expenses on the day of service and agree to a billing fee of $15.00 if not collected by the office at my appointment time. If at any time my check is returned to the office for insufficient funds, I also agree to a charge of $50.00 to cover banking fees associated with my error.I have read and understand the above. I attest to the accuracy of the information contained on this page.Patients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Patient/Guardian/Personal Rep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed name of Patient/Guardian/Personal Rep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_C:\Users\l2\Desktop\NVD Logo - Purple (2).jpg  |

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**X-ray compliance, assignment and release**

We will require that certain x-rays be taken on a periodic basis as they provide important diagnostic information to detect early stages of decay, oral disease and serious health concerns such as cancer, heart disease, diabetes and other. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend *may* not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. We will not accept legal liability if you choose to decline having x-rays taken that we recommend. You will be asked to sign a form refusing the recommended treatment, but we will not accept this waiver beyond a 2-year limit for Bite Wing x-rays or beyond a 5-year for a Panoramic. Periapical x-rays will also be taken as necessary for treatment. Be aware that it is office policy that radiographs be taken, and your refusal will be detrimental to your patient status. As always, our patient standard of care is our priority.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners.

 I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and that I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I understand the dental practice cannot be held responsible for any services not paid for and/or denied by my insurance company as we are not party to the insurance contract held between you and your insurance company. I agree to pay all estimated out of pocket expenses on the day of service.

I, (Patient name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to be a patient at Naples Valley Dental and agree to radio-graphics and clinical examinations. I also understand and consent to all the above contained in this document.

Signature of Patient/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Reservation/Cancellation Policy**

Our Practice is sensitive to busy schedules. We strive to provide high quality dental care in the most efficient manner possible. Because we value your time, we reserve a place for you to see a hygienist, assistant and the dentist. Your reservation helps us ensure we utilize our time most effectively and ensure other patients receive the same quality care that you receive. Your reservation ensures that the time reserved is of supreme quality with our highly credentialed, professional staff.

We do, however, understand circumstances arise and reservations need to be cancelled or rescheduled. We ask when this situation arises, that you give us at least 48 business hours’ notice, ahead of your reservation time, to allow us time to fill the schedule as there are always several patients waiting to be seen. We will work with you to get your appointment rescheduled as soon as possible. Understand that any less than that allowed time will disrupt the quality time other patients can receive and we then reserve the right to charge a late cancellation fee of $35.00 per event. A broke reservation without notice or a "No Show" will result in a $50.00 charge and/or possible dismissal from the practice. This shows a lack of respect and a blatant disregard for our time and of others in our dental family, who value us as their chosen dental provider. You are welcome to call and discuss this with us if this was a true mistake on your part. The fees associated with broke appointments are the responsibility of the patient and or guarantor of the account and must be paid in full before the next family appointment. Cancellation fees in some instances may be waived at the discretion of management as our private, family dental practice firmly believes that a positive provider/patient relationship is based on understanding, good communication and mutual respect.

While we hope all reservations are adhered to at our office, please understand that emergencies arise (both in and out of the office) and schedules may fall behind from time to time. We ask for your patience and understanding that if it were your care that was being attended to and your treatment required the extra time and care, that we would do the same for you and your family as well.

Also be aware that reservation times may shift slightly on occasion to accommodate other changes in our schedules. We will make every effort to notify you either through electronic or direct contact and apologize for any inconvenience that this may cause.

With your permission, the practice will communicate these reservation reminders via text, email and phone calls (which include voice mails) using phone numbers associated with your account. Also, please be aware that if you do not confirm your appointment with our office, you will run the risk of being pulled from that days’ schedule.

I, (Patient name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand and consent to be a patient at Naples Valley Dental and agree to the aforementioned information contained in this document.

Signature of Patient/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_



**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION/HIPAA**

I, (patient/guardian name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize the release of my or my dependent’s (patient name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_confidential protected dental information, as described in the AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information. This information may include my dental treatment, condition or information contained within my dental chart and history for purposes of my health care. I also give permission for messages to be left on my voicemail, text and/or e-mail of any listed numbers in my account. I also confirm that I have been offered a copy of the office notice of privacy. The following person (if any), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been granted permission by me to speak and or receive information on me or my dependents on my behalf regarding my dental treatment, diagnosis, scheduling, and billing.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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