

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

Date _____ Phone (____) _____ Alt. Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

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

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

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

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

MEDICATIONS: List medications you are currently taking:

ALLERGIES

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

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

FINANCIAL POLICIES FOR ROWLAND FAMILY DENTISTRY

Our goal is to help remove financial barriers so that our patients can receive the dental treatment they need and desire. Prior to scheduling any treatment, we are happy to provide patients with an estimate of costs. Many patients have some type of insurance. In the majority of cases, we are able and pleased to assist you in maximizing your benefits. At your first visit, we will ask you for current insurance information. We may ask you to confirm this information at subsequent visits, so we can remain up-to-date and fully informed to serve you. Insured patients will receive cost estimates broken down by insured and uninsured costs. We ask that you pay uninsured costs the day services are rendered.

Dental Insurance

Our practice understands that our patients rely on their dental insurance benefits to help defray the costs of dental services. We are happy to assist you in filing your claim with your dental insurance company. We will communicate with your insurance company and send them additional information if necessary so that eligible benefits are reimbursed to you in a timely manner. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. If your dental plan does not pay within 60 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan.

Please be aware that we are not a Medicare/Medicaid provider.

Payment Options

Patients are asked to pay for services as they are provided. We accept cash, checks, debit and credit cards. (MasterCard, Visa, Discover) We also offer flexible financing options (see below) because we understand that monthly payments can help patients fit the costs of dental treatment into their budgets.

CareCredit Financing

We offer financing through CareCredit for those who qualify. With CareCredit, you can finance 100% of your dental treatment and there are no upfront costs, no annual fees, and no pre-payment penalties. CareCredit offers a full range of payment plans, so you can find one that works well for you. CareCredit also allows for revolving payments with a variable interest rate and up to 12 months of 0% interest. It can be used by the whole family for ongoing treatment without having to reapply.

Our Scheduling Services

We schedule our patient per appointment because you deserve exclusive, personal time with our doctors and staff. We strive to run on time so you won't be kept waiting, and we ask you to arrive for your appointments on time as well. We understand that you are busy, and your time is valuable to us! We pride ourselves on keeping to our schedule and only deviate from it in the event of dental emergencies.

Please call at least two business days in advance for changed appointments. Missed appointments without this notification, or repeated cancellations, will incur cancellation fees. We want to work with you to schedule convenient appointments for your visits to our office.

We Look Forward to Hearing from You

Rowland Family Dentistry is pleased that you have chosen to become part of our patient family. If you have any questions about our financial policies, please feel free to call our office. We want to accommodate you and your budget so you can get the dental treatment you need without the burden of an overwhelming bill. We are here to make your visit as convenient and easy as we can.

Signature _____ Date _____

Rowland Family Dentistry

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****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}

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).