BALANCED DENTAL

Date: _____ Home Phone:_____ Cell Phone: _____

Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

Preferred Name: _____ Are you the responsible party? Yes No

Address: _____
ADDRESS CITY STATE ZIP

Year round resident: Yes No If no, which months: _____

Date of Birth: ____/____/____ Marital Status: _____ Gender: Male Female

Social Security #: _____-_____-_____ Driver's License #: _____

Appt Reminders: ☐ Phone ☐ Text ☐ Email: _____ ☐ All
SELECT ONE AT LEAST ONE

In case of emergency: _____
NAME PHONE RELATIONSHIP

.

Referred by: ☐ Friend/Relative/Family. Please Thank:_____

. ☐ Insurance ☐ Internet ☐ Newspaper ☐ Facebook ☐ Other: _____

Preferred Pharmacy: _____
STORE NAME LOCATION PHONE

PARTY RESPONSIBLE FOR PAYMENT IS:

☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

INSURED POLICYHOLDER IS:

☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

Name:_____ Policy Holder Name:_____

Date of Birth: _____/__/_____ Date of Birth: _____/__/_____

Social Security #:_____-_____-_____

Phone:_____ Insurance Company:_____

Insurance Phone:_____

Group #:_____ Policy#/Member ID:_____

Policyholder Employer:_____
EMPLOYER NAME CITY STATE

If you carry PPO dental insurance, please provide a copy of your insurance card. As a courtesy, we will submit dental claims to your insurance company. By signing below you understand that you are responsible for payment to Balanced Dental for all services not covered by your insurance. In the event that your account is turned over to an attorney or collection agency due to non-payment, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts.

INFORMED CONSENT: I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH MY INFORMED CONSENT.

Signature: _____ Date: _____

☐ Adult Patient ☐ Spouse ☐ Parent ☐ Guardian ☐ Other:_____

BALANCED DENTAL

NAME: _____ DATE: _____

PRIMARY REASON FOR APPT: ☐ Exam ☐ Emergency ☐ Consultation

We understand nobody likes paperwork, however, accurately answering the following questions will allow us to provide you with the individualized care you need. Your answers will remain confidential and will only be used for your assessment. We appreciate your time and consideration.

DENTAL HISTORY

	Yes	No
1. Are you currently experiencing discomfort? Describe: _____	☐	☐
2. Have you seen a dental care provider on a routine basis? Last visit: _____ Cleaning: _____	☐	☐
3. Approximate date of full mouth xrays (16 films or panoramic): _____		
4. Name of last dentist (optional): _____		
5. Reason for leaving (optional): _____		
6. Have you ever been treated for periodontal/gum disease? Procedure type: _____	☐	☐
7. How often do you brush? _____		
8. Does dental treatment make you nervous? Explain: _____	☐	☐

Have you experienced any of the following:

Yes	No		Yes	NO	
☐	☐	Bleeding or sore gums	☐	☐	Loose teeth
☐	☐	Unpleasant taste/bad breath	☐	☐	Sensitive to hot
☐	☐	Burning tongue/lips	☐	☐	Sensitive to cold
☐	☐	Fever blister on lip or mouth	☐	☐	Sensitive to sweets
☐	☐	Swelling/lumps in the mouth	☐	☐	Discomfort when biting
☐	☐	Ortho treatment/braces	☐	☐	Food often getting stuck/impacted
☐	☐	Biting cheeks or lips	☐	☐	Clenching or grinding
☐	☐	Clicking/popping jaw	☐	☐	Change in bite
☐	☐	Difficulty open/close jaw	☐	☐	Shift in bite

Do you use any of the following:

Yes	No		Yes	No	
☐	☐	Manual toothbrush	☐	☐	Dental floss
☐	☐	Electric toothbrush	☐	☐	Waterpik
☐	☐	Mouthwash	☐	☐	Toothpaste for sensitive teeth

Smile guide

Yes	No		
☐	☐	Do you like your smile?	Rank your smile from **1 2 3 4 5 6 7 8 9 10**
☐	☐	Do you like the color of your teeth?	1= very unhappy 10= very happy
☐	☐	Do you like the position of your teeth?	What do you think can be done to make your teeth a 10?
☐	☐	Do you like the shape of your teeth?	_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

BALANCED DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

AND

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____**Phone**_____

Patient address _____

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received (or have been offered) a copy of Balanced Dental's **NOTICE of PRIVACY PRACTICES.**

Signature _____ **Date** _____

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

It is completely your decision whether or not to sign this portion of the form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I authorize Balanced Dental to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] in accordance with the **NOTICE of PRIVACY PRACTICES.**

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES.

Patient Signature _____ **Date** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Source of Authority_____

BALANCED DENTAL

Scheduling, Financing and Billing Policies

Balanced Dental is devoted to educating our patients so that together we may make informed decisions about your treatments. We believe no question should be left unanswered, including financial questions, which is why we discuss cost before treatment. We understand that dentistry can be costly and that not everyone has dental insurance. As part of our commitment to provide you with caring, quality dentistry, we offer reasonable fees, a variety of payment options and financing plans to make your treatment as affordable as possible.

Financing

We participate with many forms of PPO based insurance and we file all insurance claims on your behalf. We accept many forms of payment, including cash, check and all major credit cards. Additionally, we have low-rate financing options. These programs offer low monthly payment options, no upfront costs or prepayment penalties and are quick and easy to apply for. If you have specific financial concerns, we would be happy to discuss those and work out alternative financial arrangements that benefit both parties.

Cancellation Policy

You will find that our office respects and values your time and we make every effort to remain on schedule. In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to make an appointment. This time will be given to someone who is in urgent need of care. Any appointment not cancelled within 24 hours (1 Business day) advance is subject to a $50 cancellation fee. Cancellations may only be accepted over the phone.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms.

_____ _____ _____

PRINTED NAME **SIGNATURE** **DATE**

Patient Billing Policy

To keep fees down for our patients, we do require payment at the time service is rendered. Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage. Any patient account over 90 days past due is subject to collection by a third party collection agency and/or small claims court. By signing below you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, all costs, and expenses, including reasonable attorney's fees, which may we incur in such collections efforts.

I have read and understand the Patient Billing Policy of the practice and I agree to be bound by its terms.

_____ _____ _____

PRINTED NAME **SIGNATURE** **DATE**