Today's Date: _____

Patient Information

Name, Last: _____ First: _____ Middle: _____ DOB: _____

Gender: Male____ Female____ Marital Status: Single_____ Married_____ Divorced_____ Widowed_____

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

Address: _____ City: _____ State_____ Zip_____

Home Phone #: _____ Work #: _____ Cell #: _____

Pharmacy Name: _____ Pharmacy #/Address_____

E-mail address: _____ Best way to reach you: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____

Spouse or parent's Name: _____ Employer: _____ Work #:_____

Have you or any member of your family been a patient at this office before? Yes_____ No_____

Who may we thank for recommending our office to you? _____

Otherwise, how did you learn about our practice? Insurance_____ Internet_____ Mailer_____ Other_____

Parent/Guardian Information (if patient is a minor):

Name: _____ Relationship to patient _____

Birth Date: _____ Social Security #_____ Driver's License# _____

Address: _____ City: _____ State: _____ Zip: _____

Dental Insurance Information

Policyholder's Name: _____ Birth Date: _____ Social Security# _____

Insurance Company: _____ Group #_____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self_____ Child_____ Spouse_____ Other_____

THE GENTLE ART
OF DENTISTRY

Dental History

What is the primary reason for your dental visit today?_____

Your last complete exam: _____Your last complete x-rays:_____ Your last dental cleaning: _____

If your dental treatment was not completed, what prevented your from receiving it? Time, Cost, Fear, Other

Do you snore or have sleep apnea? Yes_____ No_____

Please circle any of the following problems that apply to you

Sensitivity (hot, cold, sweets)	Bleeding, swollen, or irritated gums	Tooth Pain when chewing
Loose, tipped of shifting teeth	Teeth or Fillings breaking	Dry Mouth
Jaw Joint Pain	Bad Breath or bad taste in your mouth	Grinding/clenching teeth

Please indicate current/past dental treatments: (please circle)

Treatment for TMJ Wear a night guard Braces

Dentures/partial dentures, how old _____ Dental Implants, when_____

Deep cleanings/periodontal treatment, when_____Teeth extracted (adult teeth) when_____

If you could whiten your teeth for a cost you could afford, would you do it? Yes_____ No_____

If you could change anything about your smile it would be:

- ☐Make them brighter
- ☐Make them straighter
- ☐Close spaces
- ☐Replace metal fillings with tooth colored fillings
- ☐Repair Chipped Teeth
- ☐Replace missing teeth
- ☐Alternative to a denture
- ☐Replace old crowns that don't match
- ☐Get a smile makeover

On a scale of 1-10, with 10 being the highest

How important is your dental health to you? _____ How would you rate your current dental health? _____

Medical History

Please check any of the following that **APPLIES TO THE PATIENT**:

☐Aids/HIV	☐Anemia	☐Arthritis	☐Artificial joints	☐artificial heart valve
☐Seasonal Allergies	☐Asthma	☐Blood Disease	☐Bruise easily	☐Cancer
☐Chemotherapy	☐Diabetes	☐Dizziness	☐Drug Addiction	☐Emphysema
☐Excessive bleeding	☐Fainting	☐Glaucoma	☐Heart Conditions	☐Heart murmur
☐Hepatitis A/B/C	☐High blood pressure	☐Low Blood pressure	☐Jaundice	☐Kidney disease
☐Mitral valve prolapse	☐Anxiety/Depression	☐Pacemaker	☐Osteoporosis/penia	☐Radiation
☐Respiratory illness	☐Rheumatic fever	☐Rheumatism	☐Seizures	☐Stomach problems
☐Stoke	☐Thyroid disease	☐currently pregnant?	☐Liver Disease	☐Latex allergy
☐Allergies to antibiotics	☐Tuberculosis	☐ Phen-Fen (diet pills)	☐Other medical conditions_____	

Do you smoke or use chewing tobacco? Yes_____ No_____ How much?_____How long?_____

Do you use any recreational drugs? Yes_____ NO_____ Which drugs? _____

What medical conditions are you currently being treated for? _____

Physicians name: _____ Phone#_____ Fax#_____

Medications you are currently taking:_____

Please list any medications you are allergic to or have bad reactions to: _____

Are you now, or have you in the past, taken a bisphosphonate drug? _____

To the best of my knowledge, I have answered every question completely and accurately. It is my responsibility to inform the Dental of any changes in my health and or medications.

Parent/Guardian Signature _____Print Name _____Date_____

J. Scott Anderson D.D.S., P.L.L.C
Financial Guidelines

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have a complete understanding of your financial responsibilities for the services to be provided. To assist us in achieving these goals, we ask that you review our financial policy.

Unless payment arrangements have been approved in advance by authorized staff, payment in full will be due at the time services are rendered. We do not balance bill. We will be happy to process your dental insurance claim, and by signing this form you are giving authorization for the insurance company to pay us directly for any treatment rendered.

At the time of your appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we estimated will not be covered by your dental insurance. Due to insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from this estimate and calculations on the insured pre-estimate. If your insurance company has not paid in full 60 days from treatment day, you will be responsible for paying the balance.

Please remember that your insurance is a contract between you and your insurance company and/or employer. Our dental practice is not a party to the contract. We recommend that any questions regarding the amount of coverage for specific treatment be discussed directly with your insurance company or employer.

A finance charge of 1.5% per month may be assessed to any outstanding balances over 30 days from the date of treatment. (This finance charge represents and Annual percentage rate of 18%). If your check is dishonored or returned for any reason you expressly authorize our office to electronically debit your bank account for the amount of the check, plus a **$25.00 NSF** processing fee. Your use of a check for payment is your acceptance of this agreement and its terms.

All treatment charges are the responsibility of the patient or responsible party regardless of insurance coverage. In the event of non-payment, the patient or responsible party agrees to pay all cost of collections including, but not limited to attorney fees, court cost, collections agency fees, etc…

ALL SEDATION CASES MUST BE PRE-PAID, NO EXCEPTION CAN BE MADE
Sedation appointments require specialized monitoring over an extended block of time exclusively set aside for that particular patient. For this reason, all sedation cases must be pre-paid upon scheduling

Missed appointments/Short notice cancellations
Without 48 hours advance notice, there will be a fee of $50 for any missed appointment. The missed appointment fee must be paid prior to future office visits.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THIS PRACTICE AND AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED FROM TIME TO TIME BY THE PRACTICE AND BY SIGNING THIS POLICY GIVES THE INSURANCE COMPANY MAY PERMISSION TO PAY J.SCOTT ANDERSON D.D.S DIRECTLY FOR DENTAL SERVICES.

Signature of
Parent/Patient/Guardian_____ Date _____

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)

_____

_____

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA) and House Bill 300, in order for your healthcare provider or staff of J. Scott Anderson, D.D.S to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules be waived.

☐ I do not authorize J. Scott Anderson, D.D.S to release any or all information concerning my medical care to any individual except as set forth above.

☐ I authorized J. Scott Anderson, D.D.S to verbally release any or all information concerning my medical care to the following individuals.

Name_____ Relationship to pt_____

Name_____ Relationship to pt_____

Name_____ Relationship to pt_____

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date