Dental Group of ELLISVILLE

Nichole Racey, DMD

Patient Information

Patient Name: _____ Date of Birth: _____
(First) (MI) (Last)

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

Social Security #: _____ Please select one: ☐ Male ☐ Female Age: _____

Patient Employer/School: _____ Occupation: _____ Email: _____

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Best time to reach you is: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name: _____ Relationship: _____

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Please Select One: ☐ Married ☐ Divorced ☐ Single ☐ Minor ☐ Widowed

Spouse Name: _____ Spouse DOB: _____
(First) (MI) (Last)

Spouse Social Security #: _____ Spouse Employer: _____

How did you hear about us? _____

If referred, who may we thank for referring you? _____

Responsible Party Information

If the Patient is the responsible party, please check here, skip this section and continue onto Primary Dental Insurance

☐ I am financially responsible for my account

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ both ☐ neither-not applicable

Name: _____ _____ _____ _____
(Last) (First) (MI) (Preferred Name)

Title: _____ **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** _____ - ___ - _____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
(Home) (Mobile) (Work) (Ext.) (Fax) (Other)

Address: _____ _____
(Address 1) (Address 2)

_____ _____ _____
(City) (State) (Zip Code)

Dental Insurance

Insurance Company: _____ Group # _____

Who is responsible for this account? _____ Union or Local # _____

Subscriber's Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to patient: _____

Employer: _____ Work #: (_____) _____

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

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Dental History

Reason for today's visit: _____ Date of last dental visit? _____

Former Dentist: _____ Phone: (_____)_____ Date of last dental X-ray? _____

Check if you have or have had a problem with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Sores or growths in your mouth
- ☐ Clicking or poppping jaw
- ☐ Food collecting between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to cold or hot
- ☐ Sensitivity to sweets

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

Medical History

Physician's Name: _____ Date of last visit? _____

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

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, explain: _____

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

(Women only) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Check if you have or have had problems with any of the following: (Please check all that apply.)

- ☐ Anemia
- ☐ Arthiritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Veneral Disease

List of medications you are currently taking: _____

_____

Allergies:

- ☐ Aspirin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Iodine
- ☐ Sulfa
- ☐ Barbiurates (Sleeping Pills)
- ☐ Penicillin
- ☐ None

Other _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

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Caries Risk Assessment Survey

High Moderate Low

Patient's Name: _____ Age:_____ Date:_____

Many of our patients express concern over having cavities. In fact, dental caries remains the most common threat to early childhood oral health. However, children are not the only ones at risk but many adults also face higher risk due to medical issues, dietary habits, and side effects from common medications.

The goal of this assessment form is to help us determine what your personal risk status is for decay. Please fill out the "Patient Use" section to the best of your ability. With this information, we will be able to discuss the appropriate preventive measures available to you to reduce your risk for cavities.

Risk Factors (Patient Use)

Do you notice plaque build-up on your teeth between brushing? ☐ Yes ☐ No

Do you take medication daily? If yes, how many? ☐ Yes _____ ☐ No

Do you feel like you have dry mouth at any time of the day? ☐ Yes ☐ No

Do you drink liquids other than water more than 2 times daily between meals? ☐ Yes ☐ No

Do you snack daily between meals? ☐ Yes ☐ No

Do you have oral appliances present? ☐ Yes ☐ No

Do any of these health concerns apply to you? (check all that apply) ☐ Frequent Tobacco Use ☐ Diabetes ☐ Recreational Drug Use ☐ Acid Reflux ☐ Bulimia ☐ Sjogren's Syndrome ☐ Head/Neck Radiation

Professional Assessment (Clinician Use)

Plaque/Calculus	Generalized	Localized	Minimal
New/Progressing Visible Cavitation	Yes		No
New/Progressing Radiographic Radiluncencies	Yes		No
Exposed Roots	Yes		No
Deep Pits of Fissures	Yes		No
White Spot Lesions	Yes		No
Cavity Diagnosed in the Last 3 Years	Yes		No
Uses Fluoride Toothpaste or Mouthwash	Yes		No
Drinks Fluoridated Water	Yes		No
Supplements Xylitol Gum/Mint	Yes		No

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NOTICE OF PRIVACY/CONSENT FORM

I, _____, understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow up amount the multiple healthcare providers who may be involved in that treatment directly and indirectly; Obtain payments from third party payers; Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that my medical records including x-rays may be sent via protected or encrypted email or mail.

I understand that if I have a concern about the privacy of my medical records, I can contact Dental Group of Ellisville, or concerns can be submitted directly to the United States Department of Health and Human Services.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I give the staff of Dental Group of Ellisville permission to contact me by the following methods:

_____ Call me, including leaving a message on my voicemail or answering machine.

_____Send emails.

_____Send texts.

_____ Send post cards.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

Dental Group of ELLISVILLE

Financial Policy

Welcome to our practice and thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care using the material, technology and tools necessary to recommend personalized treatment based upon your dental needs, not based on insurance coverage. This financial policy is intended to facilitate our ability to continue to provide you with excellent dental services.

(1) Payment in full is expected at time of service.

(2) We accept cash, credit, or offer monthly payment plans via our preferred third party vendors, including Care Credit and Sunbit.

(3) Patients under the age of 18 must have an adult (guardian) above the age of 21 accompany them, and the guardian is responsible for the full payment.

(4) For unaccompanied minors, non-emergency treatment will be denied unless prior financial arrangements have been made.

Each of the following is a statement of our financial policy, which is required to be read, initialed, and signed prior to any treatment. Please initial below in agreement to the following statements before signing below:

_____ I understand that it is my responsibility to provide accurate and up to date dental insurance information.

_____ I understand that payment is due at the time of services rendered and I assume full responsibility for the charges incurred, including anything not covered by my insurance provider.

_____ I understand that the estimate given is not guaranteed to be the exact amount, since benefits cannot be fully determined until the insurance claim is filed. Your insurance is billed as a courtesy to you and although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

_____ I understand that certain procedures are not considered a covered procedure benefit under all dental insurance plans and as such, your insurance will not pay for these services. I understand I will be responsible in full for the cost of non-covered procedures.

_____ I understand that in the event of a returned check, a $35 returned check fee will be assessed to my account.

_____ I understand that if I do not make payment arrangements on any patient portion of my balance, my account will be sent to collections and accrue a collections fee totaling up to 50% of the remaining balance on the account at the time of default.

_____ I understand that if this account goes into default, I will be responsible for all court costs, attorney fees, and any other associate fees.

_____ I understand that all prior balances (excluding insurance claims pending) will need to be paid in full before subsequent services are rendered.

In certain circumstances, insurance companies may send payment directly to you. In such cases, you agree to endorse and send the check to our dental office. If you deposit the check from the insurance company, you agree to send a personal check for the equivalent amount to our office within 10 days of the deposit.

Assignment of Benefits

_____ I hereby assign all dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment directly to this office.

Authorization to Release Information

_____ I hereby authorize Dental Group of Ellisville to: (1) Release any information necessary to the insurance carrier regarding my care and treatment, (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature and this form to be used to process insurance claims on my behalf until revoked by me in writing.

I have read the above Financial Policy. I understand and agree to the terms stated above.

X _____ X_____ Date_____

Signature of Patient or Responsible Party Printed Name of Responsible Party