

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

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

Birth Date: _____ SS#: ____-____-____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

The following is for: ☐ the patient ☐ the person responsible for payment ☐ both ☐ not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2
City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

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

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Company Phone Number: _____

Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Company Phone Number: _____

Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached you teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste in your mouth or bad breath
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, unless previously written financial arrangements have been made, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

General Consent

Examination and X-Rays:

I understand that most examinations routinely required X-rays in order to complete the examination, diagnosis and treatment plan. I understand that I will be provided a treatment plan with estimated costs prior to treatment being rendered.

Changes in Treatment Plan:

I understand that treatment recommendations are subject to change and may involve the addition of more procedures due to new conditions found while treatment is being rendered. One such example being the need for root canal therapy following routine restorative procedures. I hereby give Logos Dentistry and its staff permission to make any changes and additions as needed.

Medications and Anesthetics:

I understand that there is an element of risk inherent in the administration of any drugs or anesthetic. This risk includes, but is not limited to allergic reaction resulting in redness and swelling of tissue, pain, itching, nausea, vomiting and/or in severe cases, anaphylactic shock. Other possible effects include but are not limited to aspiration, discoloration, injury to blood vessels and nerves that may be caused by injections of medications, drugs and anesthetics. I have informed the Dentist of any known allergies.

TMD (Temporomandibular Joint Dysfunction):

I understand that routine dental treatment involving holding the mouth open, may subsequently result in the development of, or intensifying of 'clicking', 'popping', locking and pain of the lower jaw joint. Although symptoms associated with TMD are usually temporal and tolerated by patients, I understand that should the need for treatment arise, I will be referred to a specialist and will be responsible for the cost of treatment.

☐ * **By checking this box, I acknowledge that the foregoing information is a General Consent to treatment, and as such is not exhaustive in nature. 'Procedure Specific Consent' containing pertinent information relevant to the procedures will be provided prior to treatment commencement. I am also aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedures.**

Cancelled or Missed Appointment Policy

Please see our Appointment Cancellation/No Show Policy below: P

- . Any established patient who fails to show or cancels/reschedules an appointment (except for illnesses or emergency reasons) and has not contacted our office with at least 24 hours notice will be charged a \$50.00 fee. n
- . Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a \$100.00 fee. .
- . If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from Logos Dentistry. .
- . Any new patient who fails to show or cancels/reschedules with no 24-hour notice for their initial visit will not be rescheduled. .
- . The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit. .

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact us.

☐ * **I have read the information above regarding cancelled or missed appointments. This will serve as my electronic signature.**

Response Date: _____