Open and Affordable Dental and Braces®

NEW PATIENT FORM

How did you hear about us? ☐ Internet search ☐ Social media ☐ Mailer ☐ Insurance ☐ Friend (Name) _____

Patient's Name _____ Soc Sec # _____
Last Name *First Name* *M.I.*

Address _____
City _____ State _____ Zip _____
Mobile Phone # _____ Email _____
Sex ☐ M ☐ F Date of Birth _____ Employer _____
Emergency Contact Name & Number _____

PRIMARY DENTAL INSURANCE COVERAGE

Primary Subscriber _____ Relation to Patient _____
Last Name ***First Name*** ***M.I.***

Date of Birth _____ Soc Sec # _____ Phone # _____
Primary Subscriber Employer _____ Insurance Company _____
Group # _____ Subscriber/Member ID # _____

SUPPLEMENTAL DENTAL INSURANCE COVERAGE

Supplemental Subscriber _____ Relation to Patient _____
Last Name ***First Name*** ***M.I.***

Date of Birth _____ Soc Sec # _____ Phone # _____
Supplemental Subscriber Employer _____ Insurance Company _____
Group # _____ Subscriber/Member ID # _____

MEDICAL HISTORY

Are you taking any medications, pills, drugs, or controlled substances? ☐ Y ☐ N If yes: _____
_____
_____

Are you taking blood thinners: Plavix, Coumadin, Warfarin, or Xarelto? ☐ Y ☐ N If yes: _____
Have you ever taken: Actonel, Boniva, Fosamax or any other
medications containing bisphosphonates? ☐ Y ☐ N If yes: _____
Have you been requested to take any antibiotic premedications
due to heart conditions or artificial joints? ☐ Y ☐ N If yes: _____
Do you use tobacco? ☐ Y ☐ N
Do you have or are you being treated for High Blood Pressure? ☐ Y ☐ N

Women: Are you…
☐ Pregnant/Trying to get pregnant? If yes, due date _____ ☐ Nursing ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Acetaminophen (Tylenol)	☐ Clindamycin	☐ Doxycycline	☐ Latex	☐ Metal
☐ Aspirin	☐ Codeine	☐ Hydrocodone/Oxycodone	☐ Local Anesthetics	☐ Penicillin (Amoxicillin)

Other allergies? ☐ Y ☐ N If yes: _____

Check whether you have or have had any of the following:

☐ AIDS/HIV Positive	☐ Cancer	☐ Fainting	☐ Hepatitis	☐ Liver Disease
☐ Anaphylaxis	☐ Chemotherapy	☐ Glaucoma	☐ Herpes/Cold Sores	☐ Pacemaker
☐ Artificial Heart Valve	☐ COPD	☐ Heart Murmur	☐ Jaw Pain	☐ Radiation Treatment
☐ Asthma	☐ Diabetes	☐ Heart Problems:_____	☐ Kidney Disease	☐ Stroke
☐ Blood Disease	☐ Epilepsy	☐ Hemophilia/Abnormal Bleeding	☐ Leukemia	☐ Ulcer/Colitis

Other/Comments:

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist/hygienist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist/hygienist.

_____ _____
Patient/Guardian's Signature **Date**

Open and Affordable Dental and Braces®

HIPAA CONSENT

PRIVACY PRACTICES & ACKNOWLEDGEMENT

Open and Affordable Dental Notice of Privacy Practices is posted in the office waiting room and on our website. Hard copies are also available for all patients. In accordance with the HIPAA Privacy act, all patients are required to acknowledge receipt of the Notice of Privacy Policies. By signing this form, I acknowledge receipt of Open and Affordable Dental Office Policies and Notice of Privacy Practices. I understand that the Notice of Privacy Practices contains information on the uses and disclosures of any personal health information, and I have been given the opportunity to review the Notice. I understand that the terms of the Notice may change and that I will be given a revised notice if changes occur. I understand that I may request restrictions on the uses and disclosures of information for the purpose of treatment, payment, or dental care operations. I understand that Open and Affordable Dental is not required to agree to such requests, but that if they do agree, those restrictions are binding on Open and Affordable Dental.

CONSENT

I authorize Open and Affordable dentists and hygienists to examine, take radiographs, study models, photographs, and/or any other diagnostic aids deemed appropriate and necessary, and perform treatment and therapy that may be indicated in connection with my (or my child's) dental care. I also understand that the use of anesthetic agents embodies certain medical risks.

SCHEDULING

I authorize Open and Affordable Dental to leave a voicemail, send an email, and/or send a text message to the phone/email provided on the New Patient Form for the purpose of appointment scheduling and reminders.

_____ _____

Patient/Guardian's Signature **Date**

FINANCIAL CONSENT

AGREEMENT TO PAY FOR TREATMENT

I understand that I am responsible for payment of all dental services provided in this office (whether or not insurance or third party payer is involved) and that payment is due at the time services are rendered. If I do not pay the entire balance, or if insurance is unpaid after 60 days, a billing charge, or interest will be added to my account. The billing charge will accrue at the rate of 1.5% per month, which is an annual percentage rate of 18% (or a minimum charge of $5.00). In case of default of payment, I agree to pay any and all costs in collecting this account, including but not limited to reasonable attorney's fees and court costs. I also understand the office policy is to require a minimum of one business day notice for all canceled/rescheduled appointments. If this is not possible, a fee of $40.00 that is not reimbursable by insurance may be charged to my account.

AGREEMENT TO PAY FOR NON-COVERED SERVICES

I understand that I am responsible for payment of all dental services provided in this office (whether or not insurance or third party payer is involved) and that payment is due at the time those services are rendered. Should I elect to receive a non-covered procedure(s) or treatment(s) payment for that/those service(s) will ultimately be my responsibility. Non-covered services include services that are not covered by my insurance carrier, services rendered in excess of my annual maximum benefit, or services that have been denied through prior authorization.

INSURANCE

As a courtesy to our patients, we will prepare and submit your insurance forms for reimbursement. We cannot obtain payment unless you provide us with all of the necessary information as requested above. Additionally, please understand that your insurance is a contract between you/your employer and the insurance company. We cannot in any way guarantee benefits or payment from your carrier, nor can we know the specifics of every individual plan. It is your responsibility to know the terms and limitations of your insurance plan.

Please read and understand that by signing, you are agreeing to the following:

- I authorize my insurance to pay the doctor directly all insurance benefits otherwise payable to me.
- I authorize the doctor to release any information including, but not limited to, records of treatment, or examination, person identification, x-rays, medical history, etc. to my insurance company as requested.
- Any estimates given with regard to treatment fees are only rough estimates based on limited information we have about your plan.

_____ _____

Patient/Guardian's Signature **Date**