DENTAL HEALTH FIRST, LLC

WWW.DENTALHEALTHFIRST.COM

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Welcome to our Practice

Date: ________________

Patient Name: ________________ ________________ ____ ________________
Last First MI Preferred Name

Gender: Male _____ Female _____ Other _____ **Marital Status:** Married _____ Single _____ Child _____ Other _____

Date of Birth: ________________ **SSN:** ________________ **E-Mail** ________________

Phone: ________________ ________________ ________________ ______ ________________
Home Mobile Work Ext. Other

Address: ____

City: ________________ **State:** ________ **Zip Code:** ________________ **DL#:** ________________

Whom may we thank for referring you to our practice: ________________________________

Dental Insurance

Primary:

Insurance Plan Name: ________________ **Policyholder:** ________________ **Date of Birth:** ____________

ID#: ________________ **Group #** ________________

Insured Employers Name: ________________________________

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

Secondary:

Insurance Plan Name: ________________ **Policyholder:** ________________ **Date of Birth:** ____________

ID#: ________________ **Group #** ________________

Insured Employers Name: ________________________________

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

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.

Responsible Party Information:

This ONLY needs to be completed if the insurance subscriber is not the patient, and/or you are the parent/guardian of the patient.

The following is for: the patient's spouse ________ the person responsible for payment ______ both ______ neither/NA _______

Name: ______________________________ ______________________________ _____ __________________________
Last First MI Preferred Name

Gender: Male _____ Female _____ Other _____ **Marital Status:** Married _____ Single _____ Child _____ Other _____

Date of Birth: _________________ **SSN:** _________________________ **DL#:** ________________________________

Phone: _____________________ _____________________ _____________________ _______ ____________________
Home Mobile Work Ext. Other

Address: ____

City: _____________________ **State:** ________ **Zip Code:** _______________ **E-Mail:** ____________________________________

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 x-rays: ____

I routinely see my dentist every: 3 months _____ 4 months _____ 6 months _____ 12 months _____ 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 any reactions to local anesthetic
_____You experience dry mouth
_____Have you ever whitened or bleached your teeth?
_____You wear or have worn a bite appliance
_____Noticed an unpleasant taste or odor in your mouth
_____Had any teeth become loose on their own (without injury)
_____You snore or wake up frequently during the night
_____Treated for gum disease or were told you have lost bone around your teeth
_____Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
_____Have you experienced popping and/or clicking of your jaw joint or clench or grind teeth?
_____Had trouble getting numb
_____Had/have braces, orthodontic treatment
_____Food gets trapped between any teeth
_____You have difficulty chewing
_____Gums bleed when brushing or flossing
_____Experienced gum recession

Health History

Do you require premedication for your dental visits? Y/N

Females: Are you currently pregnant? **Y/N** Taking Birth Control? **Y/N**

Are you currently being treated for any other illness? Y/N If yes, please explain. ______________________

Do you have any allergies to medications? If so, please list. ______________________

____

Do you take a bisphosphonate or blood thinner? Y/N If yes, please list medication type ______________________

____

Please list all medications you currently take: ______________________

____

Please answer each condition by choosing "Y" for yes and "N" for no.

Y/N Premed	**Y/N** Hepatitis	**Y/N** Sinus Problems	**Y/N** Asthma
Y/N Latex Allergy	**Y/N** Tuberculosis	**Y/N** Diabetes	**Y/N** Pacemaker
Y/N Artificial joints	**Y/N** Excessive Bleeding	**Y/N** Rheumatism	**Y/N** Epilepsy
Y/N Hay Fever/Allergies	**Y/N** Thyroid issues	**Y/N** Heart Disease	**Y/N** Heart Murmur
Y/N Venereal Disease	**Y/N** Mitral Valve Prolapse	**Y/N** Kidney Disease	**Y/N** Liver Disease
Y/N HIV	**Y/N** MS-Multiplesclerosis	**Y/N** Arthritis	**Y/N** Cancer
Y/N Respiratory Problems	**Y/N** Stroke	**Y/N** Rheumatic Fever	**Y/N** Dizziness
Y/N Stomach Problems	**Y/N** Tumors	**Y/N** Ulcers	**Y/N** Glaucoma
Y/N Anemia	**Y/N** Hearing Impairment	**Y/N** Blood Disease	**Y/N** Mental Disorder
Y/N Frequent Headaches	**Y/N** High Blood Pressure	**Y/N** Fainting	**Y/N** Nervous Disorder
Y/N Head injuries	**Y/N** Radiation Treatment	**Y/N** Tobacco/Alcohol use	**Y/N** Dilantin

If any conditions or alerts selected above need further clarification, please explain. ______________________

____

Who should we contact in case of emergency? Name/Relationship and Phone # ______________________

How would you rate your overall health? Poor_____ Fair _____ Good _____ Excellent _____

Physician Name and Phone Number: ______________________

Preferred Pharmacy and Phone Number: ______________________

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Patient Name: ______________________ Date: ______________

Patient Signature: ______________________ Date: ______________

Financial Policy

Thank you for choosing our practice. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

- Dr. Vaughan and Dr. Yokum participate with the following Insurance Companies: Delta Premier, United Concordia, UPMC Dental Advantage, UPMC for life, Met Life, Ameritas Life, Standard Life, Reliance, Guardian, Aetna, Cigna and Lincoln Financial.

Payment Options you may choose from:

-Cash, Check, Visa, MasterCard, Discover

-Care Credit -Convenient monthly payment plans (subject to credit approval), which allows you to pay over a period with no annual fees or pre-payment penalties

Even though we may not participate with all dental plans we will gladly submit your insurance claims on your behalf. You will be responsible for any charges your insurance company does not cover. All estimated co-pays are required when services are rendered.

Our practice requires payment prior to or at the completion of your treatment. For larger, more comprehensive treatment plans that will require multiple appointments, a 50% deposit is required to secure your initial treatment plan. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you need. To see the services we offer, look at the smile gallery, and to introduce you to our staff please visit our website at www.dentalhealthfirst.com

If you are over the age of 18, You are responsible for your dental co-pays. Any payments made by another person on your behalf are private and between you and that person Our office charges $20.00 for returned checks.

I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.

Patient Signature: ______________________________ Date: ______________

Parent or Guardian: ______________________________ Date: ______________

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,

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

Name/Relationship: ______________________________ Phone Number: ______________

Patient Signature: ______________________________ Date: ______________

Parent or Guardian: ______________________________ Date: ______________

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

Patient Signature: ______________________________ Date: ______________

Parent or Guardian: ______________________________ Date: ______________