WELCOME!

1. PATIENT INFORMATION

Date:

Last Name _____ First Name _____ MI _____

☐ Male ☐ Female SSN # _____ Marital Status: _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State _____ Zip Code _____

Email _____ Cell Phone _____

Employer _____ Work Phone _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

If under 18, Name of Parent _____ Parent SSN: _____

Parent Employer _____ Parent Phone _____

Pharmacy Name _____ Pharmacy Address _____

Reason for today's visit? _____

How did you hear about us? ☐ Drive By/Walk-In ☐ Family/Friend If checked, who? _____ ☐ Billboard ☐ Internet/Online

2. DENTAL INSURANCE INFORMATION (Primary Carrier)

Policy Holder's Name _____

Policy Holder's Employer _____

Policy Holder's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone _____

Group # _____ Payor ID _____

3. DENTAL INSURANCE INFORMATION (Secondary Carrier)

Policy Holder's Name _____

Policy Holder's Employer _____

Policy Holder's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone _____

Group # _____ Payor ID _____

4. MEDICAL INSURANCE INFORMATION (Only for IV Sedation Patients)

Policy Holder's Name _____ Insurance Co _____

Policy Holder's Employer _____ Member ID _____

Policy Holder's DOB _____ Group # _____ Insurance Phone _____

5. FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards, or one of the third-party financing options we provide.

DO YOU HAVE INSURANCE?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

☐ **Please check if you would like more information about financing options.**

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, credit card or one of the third-party financing options we provide.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

HIPAA and Financial Consent

We understand that medical information about you and your health is personal, and we are committed to protecting such information. For a detailed description of our privacy practices, please see our "Notice of Privacy Practices" at the front desk. This document also describes your rights and certain obligations we have regarding the use and disclosure of medical information. Other uses and disclosures of medical information not covered by this Notice, will be made only with your written permission.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges.

Patient Signature/Legal Guardian _____ Date _____

6. DENTAL HISTORY Please mark (x) on any of the following conditions that apply to you

Patient Name (print):

Appearance
- ☐ Discolored teeth
- ☐ Flat/worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Crowding
- ☐ Spaces/missing teeth
- ☐ Deep bite

Pain/Discomfort
- ☐ Sensitivity (hot, cold, sweets)
- ☐ Pressure/pain with chewing
- ☐ Broken teeth/fillings
- ☐ Dry mouth
- ☐ Other: _____

Function
- ☐ Grinding/clenching
- ☐ Morning headaches
- ☐ Jaw joint (TMJ) pain
- ☐ Jaw joint (TMJ) clicking/popping
- ☐ Speech impediment
- ☐ Mouth breathing
- ☐ Sore muscles (head, neck)
- ☐ Difficulty opening or closing
- ☐ Difficulty chewing on either side

Periodontal (Gum) Health
- ☐ Bleeding, swollen, irritated gums
- ☐ Bad breath Loose, tipped or
- ☐ shifting teeth
- ☐ Previous perio/gum disease

Sleep Pattern or Conditions
- ☐ Sleep apnea
- ☐ Snoring

Habits
- ☐ Thumb sucking
- ☐ Nail biting
- ☐ Cheek/lip biting
- ☐ Chewing on ice/foreign objects

Social

Tobacco or Cigarette packs per day _____

Alcohol frequency _____

Drug History/Type _____

Preferred Comfort Options
- ☐ Nitrous oxide
- ☐ Oral sedation (pill)
- ☐ IV sedation

Frequent/Daily Use:
- ☐ Soda/sweet tea
- ☐ Coffee with creamer/sugar
- ☐ Sports/energy drinks
- ☐ Candy/sweets
- ☐ High carb diet

Please share the following dates: Your last dental visit: _____ Your last cleaning: _____ Dental Office Name: _____

What is the overall goal for your visit today? _____

Have you had a bad dental experience in the past? If so, explain so we may better serve you: _____

On a scale of 1-10, with 10 being the highest rating: Dental Anxiety 1 2 3 4 5 6 7 8 9 10 **Happy with your smile** 1 2 3 4 5 6 7 8 9 10 **Dental Pain** 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile? ☐ Chipped Teeth ☐ Color ☐ Bite ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Sensitive to Hot & Cold, Sweets, or Pressure ☐ Missing Teeth ☐ WhiterTeeth ☐ _____

7. MEDICAL HISTORY

Please mark (x) as your response to indicate if you have or have had any of the following

Medical Allergies
- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local anesthetics
- ☐ NSAIDs

Other allergies/comments

_____

_____

_____

Cancer Type

_____
- ☐ Chemotherapy
- ☐ Radiation therapy

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Heart conditions
- ☐ Heart surgery
- ☐ High/low blood pressure
- ☐ Pacemaker
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease

Gastrointestinal
- ☐ Reflux
- ☐ Gastrointestinal disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood disorders
- ☐ Bruise easily
- ☐ Excessive bleeding

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness/fainting
- ☐ Drug/alcohol addiction
- ☐ Seizures
- ☐ Psychiatric illness

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Respiratory problems
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV positive
- ☐ HPV
- ☐ Cold sores

Women
- ☐ Currently pregnant Due date: _____
- ☐ Nursing

Are you under the care of a physician? If yes, please explain _____

Physician Full Name _____ Phone _____

Have you had a serious illness, operation, or hospitalization in the past 5 years? If yes please explain _____

_____

Please check if you have any of these conditions: ☐ Artificial Heart Valve ☐ Previous Infective Endocarditis ☐ Damaged Heart Valves in Heart Transplant ☐ Repaired CHD with Residual Defects ☐ Artificial Joints ☐ Unrepaired Cyanotic CHD

Please list medications currently taking: _____ _____ _____

_____ _____ _____

Are you currently taking, or have you ever in the past taken medications for Osteopenia/Osteoporosis or Bone Disease also known as Bisphosphonates? ☐ Yes ☐ No

Do you currently take Suboxone? ☐ Yes ☐ No **If yes, who is the prescribing physician?** _____ **Are you currently on blood thinners?** ☐ Yes ☐ No

If you checked yes for either question, please specify the medication, dosage, frequency, start date, and last dosage: _____

_____

Consent:

I hereby authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Signature of Patient/Legal Guardian _____ **Print Name** _____ **Date** _____

Serene View Dental Care

Cancellation Policy

Many offices subscribe to a method of scheduling that overbooks their appointment times in anticipation of patient cancellations. This works well when cancellations occur, but more often than not results in a "crunched schedule" that decreases individual appointment time to ensure every patient can be seen, but results in a major decrease in the quality of care received.

Please understand that Serene View Dental does not practice this method of scheduling. This gives more time for individual care and optimizes the quality of treatment you receive here. We reserve your appointment time specifically for you so we never compromise your care to see another patient. We understand that unanticipated events occur, however, if you are extremely late (15 minutes or more), a no-show, or cancel on short notice (less than one business day's notice), that is a lost opportunity for another patient who could have taken that time to be seen in our office.

Cancellations

When canceling any appointment, you must give at least one full business day's notice. You can accomplish this by calling the office at 601.264.7112 and speaking to a staff member, texting, or leaving a voicemail message on our office phone number. We also receive messages via Serene View Dental's Facebook and email, frontdesk@sereneviewdental.com.

A $50 fee will be charged to your account for any appointment canceled with less than one full business day's notice. For appointments less than 90 minutes, this fee must be paid before rescheduling. For more lengthy appointments, this results in forfeiture of the required deposit paid when you scheduled.

Late Arrivals

If you are running a few minutes late for your appointment, please call our office. If we cannot accommodate you, we reserve the right to reschedule your appointment to a time that is convenient for you.

Deposits

A $50 deposit will be taken to book an appointment that exceeds 90 minutes. This deposit will be credited to your estimated patient portion for treatment as outlined in your treatment plan. Deposits will be forfeited for any patient who no-shows their appointment, cancels with less than one business day's notice, or is excessively late (>15 minutes) past appointment time.

Out of respect and consideration to your doctor and other patients, please plan accordingly and be on time. Thank you for your cooperation.

***Patient/Guardian Signature** _____ **Date** _____

***Print Name:** _____

Authorization to Release Information

Many of our patients allow family members such as their spouse, parents, or children to call and request information regarding billing, treatment options, aftercare, and other important information. Due to our obligation to H.I.P.A.A. and compliance with federal mandates regarding patient confidentiality, our office cannot release this information to anyone without the patient's written consent. Suppose you wish to have your medical/dental information, treatment, or financial information released to family members. In that case, you must first list those you authorize to release this information and sign this form granting permission to release it to them.

You have the right to revoke this consent, in writing, for all future appointments by updating this form at any time.

☐ I do not authorize Serene View Dental to release my records to any individual.

☐ I authorize Serene View Dental Care to release my records and any information requested to the following individuals.

1.) _____ Relationship: _____

2.) _____ Relationship: _____

3.) _____ Relationship: _____

Patient Name (PLEASE PRINT): _____ Date: _____

Patient Signature: _____ Date: _____