Union Dental

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Email Address:_____

Street Address: _____City, State, Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

SS#: _____, Driver's License: _____ Sex: __MALE / FEMALE__ Date of Birth: _____

Employer: _____ Address, City, State, Zip _____

Emergency Contact Name: _____ Phone # : _____ Relationship: _____

Spouse's/Parent Name: _____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: _____, Place_____ Time: _____

How did you hear about our office? Please check: _____Internet _____Patient referral _____Website _____Social Media _____Mailer Other _____

If you were a referral, whom may we thank for their trust in us? _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Phone #: _____

Policy Holder Name: _____:Member's ID# _____ Birth date: _____

Group# or Policy # _____ Employer Name:_____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Union Dental of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered and understand that complete payment will be made after each treatment unless other financial arrangements have been previously arranged.

Date: _____ Patient's/Guardian Signature: _____

CONSENT:

I hereby authorize Union Dental to take the necessary x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Union Dental to make a thorough diagnosis of the patient's dental needs, lab needs; and for the use of dental education, which may include full face or smile photos. I waive any claim which might accrue to me personally on account of the use of such photographs, x-rays. I also authorize Union Dental to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Union Dental and your insurance company. I fully understand that it is my financial responsibility only for all dental treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____ Dr. Signature: _____

Union Dental

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

_____ Date _____

Printed Name of Patient

_____ *Relationship* _____

Patient or Guardian signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communications barriers (such as a language barrier) prohibited obtaining acknowledgment
_____ An emergency situation prevented us from obtaining acknowledgement at time of service
_____Other (Please specify) _____

Our Financial Policy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone. So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits.

Regarding Insurance:

We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits; however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 **days.**

WE ACCEPT CASH, CHECKS OR DISCOVER, MASTERCARD, VISA, AMERICAN EXPRESS. WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL.

I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Union Dental must take additional steps to collect my account, I will pay ALL cost of collection fees of 40% and including any court cost and attorney's fees incurred by Dr. Joseph Willardsen and Union Dental.

Cancellation Fee: Union Dental has a 48-hour cancellation policy. Any no show appointments or appointments cancelled less than 48 hours are subject to a $50/per hour cancellation fee of the appointment time scheduled.

I have read the Financial Policy. I understand, accept, and agree to this Financial Policy.

_____ _____ _____ _____

Signature of Patient or Responsible Party | Date | Witness for Union Dental | Date

MEDICAL HEALTH HISTORY

PATIENT NAME: _____ **DATE:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Your safety is very important to us. **Please circle all your answers:**

1. Yes No Have you ever been told by a Doctor that you need to take antibiotics prior to any dental treatment for artificial joints or heart conditions?
2. Yes No Have you ever had a serious head or neck injury? Explain: _____
3. Yes No Has there been a change in your health within the last year? Explain: _____
4. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____
5. Yes No Are you being treated by a physician now? Explain: _____

Name of your physician: _____ Date of last Medical Exam: _____

B. HAVE YOU EVER EXPERIENCED?

6. Yes No Chest Pains, Shortness of breath
7. Yes No Swollen Ankles
8. Yes No Jaundice
9. Yes No Recent weight loss, fever, night sweats
10. Yes No Persistent cough, coughing up blood
11. Yes No Bleeding problems, bruising easily
12. Yes No Sinus Problems
13. Yes No Difficulty swallowing
14. Yes No Joint pain, stiffness
15. Yes No Dizziness, Blurred Vision
16. Yes No Ringing in ears
17. Yes No Frequent Headaches
18. Yes No Fainting spells
19. Yes No Sleep apnea or chronic snoring
20. Yes No Seizures
21. Yes No Excessive thirst
22. Yes No Frequent urination
23. Yes No Dry Mouth

C. DO YOU HAVE OR HAVE YOU HAD:

24. Yes No Heart disease/ Heart murmur
25. Yes No Heart attack, heart defects/problems
26. Yes No Asthma
27. Yes No Rheumatic fever
28. Yes No Stroke, hardening of arteries
29. Yes No High Blood Pressure
30. Yes No TB, emphysema or other lung diseases
31. Yes No Hepatitis, A B C
32. Yes No Stomach problems, ulcers
33. Yes No Diabetes
34. Yes No Mitral Valve Prolapse
35. Yes No HIV positive or AIDS-ARC
36. Yes No Tumors, Cancer
37. Yes No Arthritis, rheumatism
38. Yes No Eye disease
39. Yes No Skin disease
40. Yes No Anemia
41. Yes No VD (syphilis or gonorrhea)
42. Yes No Herpes
43. Yes No Kidney, bladder diseases
44. Yes No Thyroid, adrenal diseases
45. Yes No Alzheimer's Disease

D. DO YOU HAVE OR HAVE YOU HAD:

46. Yes No Surgeries _____
47. Yes No Blood Transfusions _____
48. Yes No Artificial Joint _____
49. Yes No Contact Lenses _____
50. Yes No Psychiatric Care _____
51. Yes No Radiation Treatments
52. Yes No Chemotherapy
53. Yes No Prosthetic heart valve
54. Yes No Pacemaker
55. Yes No Currently taking Birth Control Pills
56. Yes No Currently Pregnant or nursing

And. DO YOU TAKE OR HAVE TAKEN:

57. Yes No Recreational drugs
58. Yes No Alcohol
59. Yes No Tobacco in any forms
60. Yes No Phen Phen diet Pills or any other diet pills
61. Yes No Fosamax/Boniva or other Bisphosphonate drugs

F. VITAMINS & MEDICATIONS: _____

_____

_____

_____

G. ALLERGIES: **LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:**

_____

H. ALL PATIENTS: Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ ***Date:*** _____ ***Reviewed by Dr.*** _____ ***Date:*** _____

DENTAL HEALTH HISTORY **PATIENT NAME: _____ Date: _____**

I. Name of your former Dentist: _____How long since you were last seen? _____

65. Is keeping your teeth important to you? [Y] [N] Explain: _____

66. On a scale of 1-10, 10 being the best, where would you rate your smile?

67. On a scale of 1-10, 10 being the best, where you rate your oral health?

68. Have you experienced any of the following problems?

Bleeding gums [Y] [N],
Bad Breath or sour taste in mouth [Y] [N]
Burning sensations in mouth [Y] [N]
Soreness in jaw [Y] [N],
Is it hard for you to open wide? [Y] [N]
Clicking or popping in jaw [Y] [N]
Do you or your parents wear dentures/partials? [Y] [N]
Sensitivity to Hot & Cold [Y] [N]
Snoring [Y] [N]
Food catching between teeth [Y] [N]
Clenching or Grinding of Teeth [Y] [N]
Pain/soreness around ears, eyes, face [Y] [N]
Stiff neck muscle [Y] [N]
Do you smoke or chew tobacco? [Y] [N]

70. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

_____

71. Is the brightness of your teeth important to you? [and] [No

72. If you could change anything about your smile which of the following would you want?

Whiter [Y] [N]
Close space or spaces [Y] [N]
Replace chipped teeth [Y] [N]
Replace missing teeth [Y] [N]
Replace old crowns [Y] [N]
Remove silver fillings [Y] [N]
Remove Stains/Spots on teeth [Y] [N]
Excess showing of Teeth [Y] [N]
Replace old plastic filling(s) [Y] [N]
Straighter [Y] [N]
Less Gum showing [Y] [N]
Reshape/resize my teeth [Y] [N]

73. Fill in this question for us please: Together, what goals would you like for your oral health lifetime care?

_____

74. In presenting your treatment plan and talking to the doctor please let us know which is best for you?:

_____ I like lots of information and details _____ I like just the basics and facts

75. **Please let us know which is most important to you when making your dental health decision. Number from 1 to 5 in order of importance. *****1 being most important and 5 being least important*** ****

_____ Quality of Care
_____ Comfort of Care
_____Finance and budget
_____ Time
_____ Relationship with Doctor and Staff

Patient Signature: _____ **Date:** _____