Campodonico Family & Cosmetic Dentistry PC

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Welcome to Arden Dental

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

Whom may we thank for referring you to our practice?

_____

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

Emergency Contact (Name & Phone): *

_____

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or if patient is under 18.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Patient 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

Employment Information:

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

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 Authorization: ◯ Yes ◯ No

☐ **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 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.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *PREMED
- ☐ AIDS/HIV
- ☐ Allergy: Codeine
- ☐ Allergy: Latex
- ☐ Allergy: Other
- ☐ Allergy: Penicillin
- ☐ Allergy: Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroid
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Multiple Sclerosis
- ☐ Nervous Disorders
- ☐ No EPI
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco User
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ X-Other(See Note)

Are you taking any of the following medications?

☐ Reclast ☐ Zometa ☐ Actonel ☐ Boniva ☐ Fosomax ☐ Aredia.

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

_____

_____

Name of your physician and your most recent physical exam:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

_____

_____

Are you currently taking any medications, drugs, pills or herbal remedies, including regular dosages of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Medications:

_____

_____

_____

☐ **By checking this box, 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.**

Dental Information

What is your immediate concern?

_____

_____

Do you like your smile? Please explain below: * ◯ Yes ◯ No

_____

_____

Previous Dentist name and how long have you been a patient there:

_____

_____

Personal History, 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 ☐ Had your bite adjusted ☐ Had any teeth removed

Bite and Jaw Joint, Check all that apply:

☐ Pain in jaw joint ☐ Problems chewing ☐ Teeth changed in last 5 years

☐ Teeth are crowding/developing spaces ☐ Chew ice/ bite nails/or have other oral habits ☐ Clench teeth/make them sore

☐ Wear/have worn a bite appliance

Tooth structure, Check all that apply:

☐ Cavities within last 3 years ☐ Dry Mouth ☐ Sensitivity to Cold/Hot ☐ Sensitivity to Sweets

☐ Sensitivity to Pressure ☐ Chipped/Broken teeth or fillings

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing/flossing ☐ Bone loss around teeth ☐ Treated for Gum Disease

☐ Bad breath ☐ History of periodontal disease in family ☐ Experienced gum recession

☐ Teeth become loose (without injury)

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

_____

_____

_____

_____

IMPORTANT FACTS ABOUT DENTAL INSURANCE

. Dental insurance is a contract between the patient/employer and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
. It is your responsibility to understand the type of insurance you have, and the benefits selected by you and your employer.
. You, not your insurance company is responsible for the feed of services rendered.
. We cannot render services on the assumption that our charges will be paid by an insurance company.

Dental Insurance Estimates

Based on the information we have from your insurance company, we will ESTIMATE your portion of dental fees. This is a good faith ESTIMATE, and cannot guarantee insurance payment totally or in part. Your insurance is a great help to pay for dental health, but often times Insurance Companies don't pay for all necessary services. Please understand that in many cases it is impossible to predict the final charges that will result from your services, as there are many variables involved in the actual service and with many special clauses and limitations that we can only know when the claim is processed. IF THERE IS A BALANCE DUE AFTER YOUR INSURANCE COMPANY PAYS THEIR PORTION, YOU ARE RESPONSIBLE FOR THE DIFFERENCE AND WILL BE BILLED FOR ANY AMOUNT UNPAID. You are responsible for any charges exceeding your benefits. Our office will assist in making collections from the insurance company by filing the necessary forms.

Treatment Fee Estimates

Dental treatment fees given are based on the treatment anticipated at the initial comprehensive examination. Some teeth may have hidden decay or fractures, affected nerves or other unanticipated conditions requiring more extensive dental treatment and a change on the initial proposed treatment plan. In situations where additional charges are involved, we will explain the reason for additional treatment needed. Our Team Members will discuss the additional fees and financial arrangements involved.

Interest

A 1.5 % monthly interest charge (18% APR) will be applied to ALL BALANCES OVER 60 DAYS PAST DUE.
In the event of default your account may be sent to an external service agency for collection, and you will be responsible with any interest and additional charges/fees that we may incur to effect the collection of the balance owed.

Returned Checks

A $40.00 charge will be applied to all returned checks.

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

PLEASE FEEL FREE TO CONTACT US IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING DENTAL TREATMENT OR FINANCIAL ARRANGEMENTS. THIS FINANCIAL AGREEMENT IS ALSO FOR ANY DEPENDANTS THAT ARE UNDER YOUR CARE.

I understand and agree to the following Financial Policies as listed above:

☐ **By checking this box, I acknowledge that I have read this statement and agree to the contents. This will server as my electronic signature for this Financial Agreement.**

We would like to thank our many patients who pay their accounts on a timely basis. Patients who care of their dental finances as well as their dental health are an asset to any dental practice. WE DO APPRECIATE YOU !

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.**

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.**

Name of patient, parent or guardian completing these forms: *

_____

_____

Relationship to patient: *

◯ Self ◯ Parent ◯ Guardian ◯ Spouse ◯ Other

Response Date: ___/___/_____