TRIUNITY FAMILY DENTAL CENTRE

Patient Information

Today's Date_____

Patient Name: First_____ MI____ Last_____ Nickname_____

Address: Street_____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Mobile_____

E-mail address_____

Sex ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Seperated ☐ Widowed

Employer_____ **Occupation**_____ **Phone**_____

In case of emergency, who should be notified?_____

Relationship to Patient_____ **Home Phone**_____ **Work Phone**_____

How did you hear about us?_____

Responsible Party Information *(if different from patient)*

Name: First_____ MI____ Last_____ **Phone**_____

Address: Street_____ City_____ State_____ Zip_____

Employer_____ **Occupation**_____ **Phone**_____

Insurance Information

Primary Dental Plan Name_____ **Phone**_____

Address: Street_____ City_____ State_____ **P/Code**_____

Name of Insured_____ **Date of Birth**_____ **ID Number**_____

Group Number_____ **Patient's Relationship to Insured**_____

Employer_____ **Employer's Address**_____

Secondary Insurance ☐ Dental ☐ Medical ☐ N/A

Secondary Plan Name_____ **Phone**_____

Address: Street_____ City_____ State_____ Zip_____

Name of Insured_____ **Date of Birth**_____ **ID Number**_____

Group Number_____ **Patient's Relationship to Insured**_____

Employer_____ **Employer's Address**_____

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Dental History

What is the reason for your visit?_____

Previous/Current Dentist_____ **Last Visit Date**_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious or difficult problem associated with previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain or discomfort in your jaw (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss?_____ **How many times a day do you brush?**_____

Type of bristles: ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it?_____

Are your teeth sensitive to heat, cold, or anything else?_____

Have you lost any teeth? ☐ Yes ☐ No **If yes, why?**_____

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other forms? ☐ Yes ☐ No

Do you have any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription, over-the-counter, or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one:_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: **Are you using a prescribed method of birth control?** ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No **Week Number:**_____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical conditions: *(select all that apply)*

☐ Abnormal Bleeding	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatic/Scarlet Fever
☐ Alcohol/Drug Abuse	☐ Epilepsy	☐ HIV+/AIDS	☐ Seizures
☐ Anemia	☐ Fainting Spells	☐ Hospitalized for Any Reason	☐ Shingles
☐ Arthritis	☐ Frequent Headaches	☐ Kidney Problems	☐ Sickle Cell Disease/Traits
☐ Artificial Bones/Joints/Valves	☐ Glaucoma	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Hay Fever	☐ Low Blood Pressure	☐ Stroke
☐ Blood Transfusion	☐ Heart Attack	☐ Lupus	☐ Thyroid Problems
☐ Cancer/Chemotherapy	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Tuberculosis (TB)
☐ Colitis	☐ Heart Surgery	☐ Osteoporosis/Paget's Disease	☐ Ulcers
☐ Congenital Heart Defect	☐ Hemophilia	☐ Pacemaker	☐ Venereal Disease
☐ Diabetes	☐ Hepatitis	☐ Psychiatric Treatment	
☐ Difficulty Breathing	☐ Herpes/Fever Blisters	☐ Radiation Treatment	

Please list any other serious medical condition(s) that you have ever had:_____

Are you allergic to any of the following:

☐ Aspirin	☐ Dental Anesthetics	☐ Latex	☐ Tetracycline
☐ Codeine	☐ Erythromycin	☐ Penicillin	☐ Other

Please list any other drugs/materials that you are allergic to:_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature **Date**

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

If this office accepts insurance, I understand that I am responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Triunity Family Dental Centre of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature **Date**

PATIENT CONSENT FORM

I understand that, I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may submit a written request explaining how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that the office may call or write to remind me of scheduled appointments, or that it is time to make an appointment. Unless I direct otherwise, the office will text, email, or call for appointment reminders, and leave a voicemail message or a message with someone in my home.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

FINANCIAL POLICY ACKNOWLEGMENT

The following information is to inform you of our financial policy. If at any time, you have questions regarding this policy, please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees reflect the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, Visa, MasterCard, Discover, and American Express. We have also partnered with third-party companies to offer the flexibility of deferred interest and extended payment options.

Check Policy: If your check is returned for any reason, we will debit your account in our office for the amount of the check plus a processing fee of $35.00.

We will communicate all recommended treatment options, and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality of dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a missed appointment fee. Should you find it necessary to reschedule an appointment, please provide us with a notice of at least two business days.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense.

Please contact your insurance carrier prior to your visit to obtain essential information that will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

IMPORTANT FACTS ABOUT YOUR DENTAL INSURANCE

- Dental insurance is a contract between the patient 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 dental insurance you have and the benefits selected by you and/or your employer.
- You (not the insurance company) are responsible for the fees of services rendered.

Patient/Parent/Guardian Signature: _____ Date: _____