Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

How Did You Hear About Us?

□ **Magazine:**	□ **Street Sign**	□ **Google Reviews**
□ **Insurance:**	□ **Postcard**	□ **Yelp**
□ **Internet Site:**	□ **Is there someone we can thank for referring you?**	□ **Other:**

Responsible Party Who is responsible for the account?	
Name:	
Relationship to patient:	
Birthdate:	
Driver's License#:	
SSN#:	
Address:	
City:	
State:	
Zip:	
Employer:	
Occupation:	**Best way to verify appt.:**
Work Phone:	□ Work
Home Phone:	□ Home
Cell Phone:	□ Cell
E-mail:	□ E-mail

Financial Arrangements	**Late Charges**
For your convenience, we offer the following methods of payment. Please check the option which you prefer:	If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). A NSF check fee of $35.00 for returned checks and$15.00 denied credit card transactions is charged . A minimum fee of $1.00 may be charged on balances. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.
□ **Cash**	
□ **Debit Card**	
□ **Credit Card**	
□ **Care Credit**	
* We collect at the time of scheduling procedures. For all other services, we collect at the time of the service.	**Signature**_____ **Date**_____

Turn Page Over →

Dental Insurance Agreement

As a courtesy to our patients, we can file claims electronically if we have the correct dental benefit information. Dental benefit plans can vary with different procedures covered or not covered. An **estimate** of the charge for any procedure or surgery you may require will be given to you upon request. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any and all balances.** You will be responsible for all collection costs, attorneys fees, and court costs. If you are unable to provide us with the information timely, we will provide you with a claim form at your appointment so that you can mail it to your dental benefit company. There are a few companies that do not allow electronic submission. If your insurance is one of these companies, we will provide you a claim form to mail at your appointment. We do not bill medical insurance. If you have questions about coverage, please contact your dental benefit company for your out of network benefits. We do not accept assignment of benefits or verify benefits prior to your first appointment. If you are able to provide us with correct dental benefit information and have questions about coverage for a procedure, we can file a pre-determination after you become a patient. If your insurance company mistakenly sends us a check for your appointment, we will issue a reimbursement in whatever manner you choose. We process these reimbursements twice a month. We require 96-hour advance courtesy notice for all non-surgical appointments, which allows us the opportunity to reappoint at a more convenient time for you and have sufficient time to offer your appointment to another patient. Failure to cancel within the 96-hour window will result in a **$75 cancellation fee for all non-surgical appointments.** All surgical appointments require a **7-day advance courtesy notice**. Failure to do so will result in a $100 or 10% of the surgical fee, whichever is greater, for all surgical appointments without 7 days of notice. Cancellations must be made via phone call and during business hours. **Messages left on voicemail, via email, or text will be deemed inadequate and assessed the appropriate fee.**

Your agree as a patient:
To Provide our office with the front and back of your dental insurance/benefit cards.
Use the current American Dental Association coding for correct reporting of procedures we provide.
We will ask your policy to pay the subscriber on the dental plan.
If necessary, we can re-file your insurance for a second time for a small fee.
Your responsibilities as a patient:
To pay fees at the time of scheduling of your treatment.
To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims if you'd like us to bill them for you.
To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay and will ask for your help if they are overly onerous to communicate with.
To pay any account balance, regardless of dental benefit expected, estimated or anticipated.

I hereby authorize payment directly to me/subscriber from my dental insurance company to the subscriber. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize this doctor named to bill on my behalf, so that I may get paid any benefits my plan allows. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to this office to provide information to my insurance company regarding my dental treatment. I also authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to other health practitioners. I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers or HIPAA agent. I permit messages to be left on my phone and/or mobile phone concerning my appointment and treatment. I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. I understand Drake Perio may ask the insurance to send me/subscriber the check and I pay them directly. If my insurance mistakenly pays Drake Perio, I have selected my reimbursement method. Alternatively, I may ask my insurance to pay the provider (at my discretion).

_____ _____

Patient or Insured Date

In order for us to file your dental insurance, please provide the following information 24 hours prior to your appointment we will need the following for each insurance company (max of two plans submitted on behalf of the patient). We can not file Medical Insurance, OHP, Medicare/Medicaid, Kaiser Permanente, BCBS/Premera.

Primary Insurance Company

Name *_____

Address *_____

Phone Number *_____

Subscriber/Policy Holder and DOB *_____

Name and DOB for Policy Holder *_____

Employer Name or Group Name *_____

Subscriber ID *_____

Group Number *_____

Payor ID for electronic claim submission*_____

Relationship to Patient & SSN (for the subscriber is required)

_____

Secondary Insurance Company

Name *_____

Address *_____

Phone Number *_____

Subscriber/Policy Holder and DOB *_____

Name and DOB for Policy Holder *_____

Employer Name or Group Name *_____

Subscriber ID *_____

Group Number *_____

Payor ID for electronic claim submission*_____

SSN for Subscriber and Relationship to Patient:

_____

Preference for Patient refund (please circle one)

- If your insurance company mistakenly sends us a check for your appointment, we will issue a reimbursement in whatever manner you choose. We process these reimbursements twice a month.

*Credit to account for future dental visits

*Check mailed to you

*A phone call

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) **Yes No DK**

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: _____

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Yes No DK

Local anesthetics _____ ☐ ☐ ☐
Aspirin _____ ☐ ☐ ☐
Penicillin or other antibiotics _____ ☐ ☐ ☐
Barbiturates, sedatives, or sleeping pills _____ ☐ ☐ ☐
Sulfa drugs _____ ☐ ☐ ☐
Codeine or other narcotics _____ ☐ ☐ ☐

Yes No DK

Metals _____ ☐ ☐ ☐
Latex (rubber) _____ ☐ ☐ ☐
Iodine _____ ☐ ☐ ☐
Hay fever/seasonal _____ ☐ ☐ ☐
Animals _____ ☐ ☐ ☐
Food _____ ☐ ☐ ☐
Other _____ ☐ ☐ ☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No DK

Artificial (prosthetic) heart valve ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐
Damaged valves in transplanted heart ☐ ☐ ☐
Congenital heart disease (CHD)
- Unrepaired, cyanotic CHD ☐ ☐ ☐
- Repaired (completely) in last 6 months ☐ ☐ ☐
- Repaired CHD with residual defects ☐ ☐ ☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No DK

Cardiovascular disease ☐ ☐ ☐
Angina ☐ ☐ ☐
Arteriosclerosis ☐ ☐ ☐
Congestive heart failure ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐
Heart attack ☐ ☐ ☐
Heart murmur ☐ ☐ ☐
Low blood pressure ☐ ☐ ☐
High blood pressure ☐ ☐ ☐
Other congenital heart defects ☐ ☐ ☐

Yes No DK

Mitral valve prolapse ☐ ☐ ☐
Pacemaker ☐ ☐ ☐
Rheumatic fever ☐ ☐ ☐
Rheumatic heart disease ☐ ☐ ☐
Abnormal bleeding ☐ ☐ ☐
Anemia ☐ ☐ ☐
Blood transfusion ☐ ☐ ☐
If yes, date: _____
Hemophilia ☐ ☐ ☐
AIDS or HIV infection ☐ ☐ ☐
Arthritis ☐ ☐ ☐

Yes No DK

Autoimmune disease ☐ ☐ ☐
Rheumatoid arthritis ☐ ☐ ☐
Systemic lupus erythematosus ☐ ☐ ☐
Asthma ☐ ☐ ☐
Bronchitis ☐ ☐ ☐
Emphysema ☐ ☐ ☐
Sinus trouble ☐ ☐ ☐
Tuberculosis ☐ ☐ ☐
Cancer/Chemotherapy/ Radiation Treatment ☐ ☐ ☐
Chest pain upon exertion ☐ ☐ ☐
Chronic pain ☐ ☐ ☐
Diabetes Type I or II ☐ ☐ ☐
Eating disorder ☐ ☐ ☐
Malnutrition ☐ ☐ ☐
Gastrointestinal disease ☐ ☐ ☐
G.E. Reflux/persistent heartburn ☐ ☐ ☐
Ulcers ☐ ☐ ☐
Thyroid problems ☐ ☐ ☐
Stroke ☐ ☐ ☐

Yes No DK

Glaucoma ☐ ☐ ☐
Hepatitis, jaundice or liver disease ☐ ☐ ☐
Epilepsy ☐ ☐ ☐
Fainting spells or seizures ☐ ☐ ☐
Neurological disorders ☐ ☐ ☐
If yes, specify: _____
Sleep disorder ☐ ☐ ☐
Do you snore? ☐ ☐ ☐
Mental health disorders ☐ ☐ ☐
Specify: _____
Recurrent Infections ☐ ☐ ☐
Type of infection: _____
Kidney problems ☐ ☐ ☐
Night sweats ☐ ☐ ☐
Osteoporosis ☐ ☐ ☐
Persistent swollen glands in neck ☐ ☐ ☐
Severe headaches/ migraines ☐ ☐ ☐
Severe or rapid weight loss ☐ ☐ ☐
Sexually transmitted disease ☐ ☐ ☐
Excessive urination ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Common Sense Financial Agreements &Reservation Policies

We consider all appointments confirmed when they are reserved. We do not double book with anticipation of patients not showing for their needed dental care. Our schedule remains open yet, fully staffed when patients cancel or fail the same day of their appointment. We **require 96-hour advance courtesy notice for all non-surgical appointments**, which allows us the opportunity to reappoint at a more convenient time for you and have sufficient time to offer your appointment to another patient. Failure to cancel within the 96-hour window will result in a $75 cancellation fee for all non-surgical appointments. **All surgical appointments require a 7-day advance courtesy notice.** Failure to do so will result in a $100 or 10% of the surgical fee, whichever is greater, for all surgical appointments without 7 days of notice. Cancellations must be made via phone call and during business hours. Messages left on voicemail, via email, or text will be deemed inadequate and assessed the appropriate fee.

Every patient in our practice receives this unique reservation and that time is reserved only for you. You can expect our team to be prompt.

Credit card (Circle One) – M/C – Visa – Disc – Amex

Credit Card # _____CSV:_____

Expiration Date:_____ Your card will be saved in a secure system.

You may refuse to leave a card and not have it stored in our secure system: HOWEVER this will mean you agree that you will be required to pre-pay for all reservations IN PERSON at the office.

You must still sign that you have read our policies and date this form to become and be a patient of record.

My signature indicates that I have read and agree to the terms. I further understand that any declined payment will result in a $15.00 service fee. I understand that by signing this document this office has a cancellation fee for all reservations and that this card and any deposit I may have paid/made on my account (regardless of payment source) will be charged in the event that I do not give notice to cancel any reservation per cancellation policies. I can request a copy of these Financial Policies at any time. I understand I have signed or been given in the past (existing patients) or have been sent with this notice (new patient receipt) info regarding the cancellation policy and I will abide by those policies when making reservations.

I understand, that at times that it may not be known if my treatment will change the day of surgery (cracked tooth, new findings, etc), due to this if my treatment plan changes (due to unforeseen circumstances), the office agrees to make me aware of those charges, which I will be made responsible for, and I agree that those charges if not paid by insurance (or if I am self-pay) can be billed to this payment method. I have been instructed to ask any and all questions before signing this agreement which I will abide by.

If not the patient list relationship:_____

Patient Name _____

Patient Signature _____ _____ Date

The card that is provided above will be charged on the day of your scheduled **reservation** only if your **reservation** is not **canceled** within the requested notice policy. This card will also be charged for any past due statements on your account.