Damonte Ranch DENTAL CARE

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Birth Date: _____ SSN: _____
Last, First MI (Preferred Name)

Mailing Address: _____
Street Apartment # City State Zip Code

Physical Address: _____
Street Apartment # City State Zip Code

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____

Email: _____ Preferred appt times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any

Driver's License #: _____ ☐ Married ☐ Single ☐ Child ☐ Other _____

Employer Name: _____ Occupation: _____

Spouse (or Parent): _____ Phone (Home): _____ (Cell): _____

How did you hear about our office? _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies: _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnant? Due Date: ____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid issues
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: _____
- ☐ Trouble getting numb for dental treatment

Sleep Apnea Questionnaire

- ☐ Do you snore loudly (loud enough to be heard behind closed doors)?
- ☐ Do you feel tired, fatigued or sleepy during the day?
- ☐ Has anyone observed you stop breathing during your sleep?
- ☐ Do you have high blood pressure?
- ☐ Is your BMI more than 35?
- ☐ Is your neck circumference over 16 inches (40cm)?

- Have you ever had any complications following dental treatment? ☐ No ☐ Yes: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes: _____

_____

- Are you now under the care of a physician (other than routine care)? ☐ No ☐ Yes: _____
- Name of Physician: _____ Phone: _____
- Please describe any health problems that need further clarification: _____

_____

- List all medications you are currently taking: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Damonte Ranch
DENTAL CARE

Patient Name: _____

Emergency Contact

Name: _____ Relation to patient:_____

Phone (home):_____ (cell):_____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group : _____

Insurance Plan Name:_____

Insured's Address (if different from patient): _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group: _____

Insurance Plan Name**:**_____

Insured's Address (if different from patient): _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

NOTE: IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED. AN INSURANCE POLICY IS A CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY AND IS NOT A GUARANTEE OF PAYMENT FOR DENTAL SERVICES.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand the information will be used by my dental care providers to help determine appropriate and healthful dental treatment. I authorize you to obtain further information from any source concerning any statement made above. If there is a change in my medical information, it is my responsibility to inform my dental care providers. I agree to be responsible for all charges and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to my claims. I hereby authorize payment of dental benefits otherwise payable to me to the dental office.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home, my cell or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

H.I.P.A.A.

(Health Insurance Portability and Accountability Act)

The *Notice of Privacy Practices* will be made available to you at Damonte Ranch Dental Care.

If you would like a copy of the HIPAA packet, please inform the office staff, and a copy will gladly be supplied to you for your records.

In compliance with the HIPAA laws, it is important for Damonte Ranch Dental Care to make you aware that any contact information you have provided us (home phone, cell phone, email address, work phone*, spouses phone, etc) may be used for the purpose of contacting you and/or leaving messages for you. These messages may contain information about scheduled appointments, financial expectations or arrangements, reason for the appointment, insurance/account information, and other information that may be helpful. (*When calling a work phone number, we do not leave messages regarding financial or personal information with anyone other than the patient or the patient's personal voicemail).

If there are contacts/phone numbers you would not want us to use for such messages, please let us know by listing them here:

_____

_____

Patient's name: _____ Date: _____

Signature of patient or Legal Guardian: _____

Financial Policy

We are committed to provide you the best possible care. Whether you have dental insurance or not, please be aware that all charges are your responsibility from the date services are rendered. We accept cash, checks, MasterCard, Visa, American Express, Discover, and CareCredit.

If you have dental insurance, please be aware that we are not contracted with any insurance company which means we are "out-of'network" with all plans. However, we are happy to help you receive your maximum allowable benefits and will file your insurance claim for reimbursement. You will be asked to pay your "estimated portion" on the day of treatment. Our computer estimates the amount due based upon the information given to us by the insurance companies and previously filed claims for the same companies. Your "estimated portion" is just that, an estimate, not a guarantee of payment from the insurance company on your behalf. Following payment from the insurance company, we will send a statement to you for any difference between the estimated and the actual amount due from you.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. Filing of insurance claims is a courtesy that we gladly extend to our patients, but please be aware that all charges are your responsibility from the date services are rendered. If your insurance company fails to reimburse this office for services rendered within 60 days, the balance will become the responsibility of you, the patient, and will be due at that time. We recommend monitoring the status of your claim periodically with your insurance company to avoid this situation.

Please also be aware that an appointment not kept is an opportunity missed to serve others in need, therefore we ask that you call us at least 2 (two) business days in advance if you need to reschedule your appointment. Failure to do so may result in a fee of $80.00 per hour scheduled with the doctor and $50.00 per hour scheduled with the hygienist.

If there is an outstanding balance due from you, we will make every attempt to provide you with adequate notices and statements of your account. However, should your account become delinquent, we have the right to send your account out of office for collection. If this occurs, please be aware that a Collection Fee of up to 50% will be added to the balance.

By signing below, I acknowledge that I have read and understand the financial policies of this office. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the entity listed above.

Patient	Date
Signature of Patient *or* Legal Designate	Staff Witness