FOUNDATIONS
DENTISTRY
COSMETIC • FAMILY • IMPLANT

NEW PATIENT INFORMATION

Welcome to Foundations Dentistry! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

1 General Information

Patient's First Name _____ Patient's Last Name _____

Nickname/Preferred name _____

Patient's Birth Date _____ Gender _____ Preferred language _____

Social Security # _____ Driver's License # _____

Street Address _____

City _____ State _____ Zip Code _____

Home # _____ Mobile # _____ Work # _____

Email address _____

How would you like to receive communication from our office? ☐ Cell ☐ Email ☐ Text

How did you hear about our office? _____

Emergency Contact _____ Emergency # _____

Family Doctor _____ Family Doctor # _____

Previous Dental Provider _____ Contact Information _____

2 Medical & Dental Insurance Information

Do you have **Medical** Insurance? ❑ Yes ❑ No

Name of Insurance Company _____

Subscriber Name _____

Date of Birth of Subscriber _____

Member ID _____ Group # _____

Do you have **Dental** Insurance? ❑ Yes ❑ No

Name of Insurance Company _____

Subscriber Name _____

Date of Birth of Subscriber _____

Member ID _____ Group # _____

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3 Privacy Practices & HIPAA

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

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

4 Consent

I, _____ , consent to be a patient at Foundations Dentistry and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. I will pay in full any cost of treatment or insurance co-payments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any costs that my insurance does not cover.
5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.
7. I consent to receiving electronic communication from the office.
8. I understand that there is a $25.00 fee for not showing up for scheduled appointments. REPEATED CANCELLATIONS OR MISSED APPOINTMENTS WILL RESULT IN LOSS OF FUTURE APPOINTMENT PRIVILEGES.

Signature of patient
(or parent if under 18) _____ Date____/____/____

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NEW PATIENT HEALTH HISTORY

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

5 General Information

Patient's First Name _____ Patient's Last Name _____

Patient's Birth Date _____

Preferred Pharmacy _____ Pharmacy # _____

6 Dental Information

- ❑ Do your gums bleed when you brush or floss? ❑ Yes ❑ No
- ❑ Are your teeth sensitive to cold, hot, sweets, or pressure? ❑ Yes ❑ No
- ❑ Does food or floss catch between your teeth? ❑ Yes ❑ No
- ❑ Have you had any problems associated with previous dental treatment? ❑ Yes ❑ No
  If yes, please explain _____
- ❑ Are you happy with your smile? ❑ Yes ❑ No
  If not, what would you change? _____
- ❑ Is your home water supply fluoridated? ❑ Yes ❑ No
- ❑ Are you currently experiencing dental pain or discomfort? ❑ Yes ❑ No
  If yes, please explain _____
- ❑ Do you grind your teeth? ❑ Yes ❑ No
- ❑ Do you have any clicking, popping or discomfort in your jaw? ❑ Yes ❑ No
- ❑ Do you have earaches or neck pains? ❑ Yes ❑ No
- ❑ Do you have any sores or ulcers in your mouth? ❑ Yes ❑ No

7 Allergies

- ❑ Acetaminophen/Tylenol®
- ❑ Acrylic
- ❑ Aspirin
- ❑ Clindamycin
- ❑ Codeine
- ❑ Erythromycin
- ❑ Fluoride
- ❑ Hydrocodone
- ❑ Ibuprofen/Motrin®/Advil®
- ❑ Latex
- ❑ Local anesthetic
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline
- ❑ Zithromax
- ❑ Other _____

Reactions _____

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8 Conditions

- ❑ Abnormal/excessive bleeding
- ❑ Angina
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Cardiovascular disease
- ❑ Congestive heart failure
- ❑ Eating disorder
- ❑ Frequent headaches
- ❑ Gout
- ❑ Hay Fever/seasonal
- ❑ Heart rhythm disorder
- ❑ Joint Replacement
- ❑ Osteoporosis/Paget's disease
- ❑ Psychiatric care
- ❑ Rheumatoid arthritis
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other
- ❑ AIDS or HIV infection
- ❑ Anxiety
- ❑ Autoimmune disease
- ❑ Breathing problems/ respiratory disease
- ❑ Emphysema
- ❑ Gastointestinal disease
- ❑ Hearing difficulties
- ❑ Hemophilia
- ❑ Kidney problems
- ❑ Mitral valve prolapse
- ❑ Other congenital heart defects
- ❑ Recurrent infections
- ❑ Severe headaches/ migraines
- ❑ Systemic lupus erythematosus
- ❑ Tumors or growths
- ❑ Valve Replacement
- ❑ Alzheimer's/dementia
- ❑ Arteriosclerosis
- ❑ Back problems
- ❑ Chronic pain
- ❑ Diabetes
- ❑ Epilepsy
- ❑ G.E. Reflux/persistent heartburn
- ❑ Heart attack
- ❑ Hepatitis, jaundice or liver disease
- ❑ Low blood pressure
- ❑ Neurological disorders
- ❑ Pacemaker
- ❑ Rheumatic fever
- ❑ Severe or rapid weight loss
- ❑ Thyroid problems
- ❑ Ulcers
- ❑ Anemia
- ❑ Arthritis
- ❑ Blood disease
- ❑ Cold Sores
- ❑ Fainting spells or seizures
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ Low pain tolerance
- ❑ Persistent swollen glands in neck
- ❑ Rheumatic heart disease
- ❑ Sinus trouble
- ❑ TMJ Disorder

9 Medical Health History

- ❑ If you have had a joint replacement please provide the date and the joint replaced: _____
- ❑ Do you drink alcoholic beverages? ❑ Yes ❑ No
- ❑ Has there been any change to your general health within the past year? ❑ Yes ❑ No
  If yes, please explain _____
- ❑ Are you taking any prescription or over-the-counter medicines? ❑ Yes ❑ No
  If yes, list here _____
- ❑ Do you have sleep apnea? ❑ Yes ❑ No
- ❑ Have you ever reacted adversely to any medications and/or injections? ❑ Yes ❑ No
- ❑ Do you use tobacco (smoking, snuff, chew, bidis)? ❑ Yes ❑ No
- ❑ Have you had a serious illness, operation or been hospitalized in the past 5 years? ❑ Yes ❑ No
  If yes, please explain _____
- ❑ Are you pregnant? ❑ Yes ❑ No
- ❑ Are you taking birth control or hormone replacement? ❑ Yes ❑ No
- ❑ Are you nursing? ❑ Yes ❑ No
- ❑ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No If yes, please explain _____
- ❑ Do you have a history of cancer/chemotherapy/radiation treatment? If yes, please explain _____
- ❑ Do you take bisphosphonates? Ex: Fosamax, Actonel, Boniva, Reclast. If yes, please explain history of use. _____

Please read the above, and ensure that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Signature of patient
(or parent if under 18) _____ Date____/____/____

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

1 Insurance Claims / Payment

(please initial) _____

As a courtesy, Foundations Dentistry will file an insurance claim for you; however, in the event that your insurance company denies payment for any reason or has not paid within 45 days, you or the guarantor will be responsible for any balance due. Also, it is your responsibility to provide current address, billing information and insurance information by carrying an updated insurance card and by following up on any issues with the insurance carrier and billing issues. We are a dental care provider; our relationship is with the patient and with the insurance company. While filing insurance claims is a courtesy that we extend to our patients, **all charges are your responsibility for the date service rendered.**

2 Payment Options

(please initial) _____

- Cash
- Check
- Credit Card
- Debit Card
- ACH Direct Payment

3 Returned Checks

(please initial) _____

All returned checks will be subject to a $25 NSF fee. You will be required to pay the original amount in addition to the $25 NSF fee before being seen for another appointment. Additionally, you may be placed on a cash/card only payment method for future appointments.

4 Credit Card Fees

(please initial) _____

There is a 3.5% service fee to be charged per credit card transaction. If you prefer not to pay the service fee, another form of payment will be necessary.

5 ACH Direct Payment

(please initial) _____

This option is for a one time payment for an invoice to be paid in full. Recurring monthly payments is NOT an option when using this payment option.

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6 Patient Account Charges & Statements

(please initial) _____

Payment is due at the time of service. Any balance due payments on your account are requested at the time of your scheduled visit. If you have no insurance plan, you will be required to pay 100% of the visit charges at the time of your visit. You may contact our billing specialist to arrange and sign a monthly payment plan if necessary.

7 Collections

(please initial) _____

If your account is over 90 days old with no payment activity, it will be transferred to GLA Collection Company for any future payment and/or correspondence. Once your account is turned over, Foundations Dentistry will not be able to accept any form of payment.

8 No Show & Cancellation Charges

(please initial) _____

As a courtesy to our physician, staff, and other patients, we require that you cancel appointments at least 24 hours in advance. Absent an emergency, there is a $25 fee for not showing up or canceling with less than 24 hours notice. As a professional courtesy, the first missed or canceled appointment is written off for whatever the reason. Any future ones after this, you will need to pay the $25 for each one missed.

By signing below, you are agreeing to and understand the above financial agreement and you acknowledge that as the patient and/or guarantor you are responsible for any charges incurred and agree to pay them as required within 30 days of receiving your billing statement.

Signature of patient
(or parent if under 18) _____ Date ____/____/____

Print name _____ DOB ____/____/____