WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name_____ _____
(First) (Initial) (Last)
Preferred Name_____Social Security #_____
Address_____
City_____State_____Zip_____Home Phone_____
Cell Phone_____Email address_____
Sex: Male Female Age_____Birthdate_____ Marital status_____
Patient employed by_____Occupation_____
Business Address_____Business Phone_____
How do you prefer to be contacted regarding future appointments: Home# Cell# Email
Whom shall we contact in case of emergency_____Phone:_____
Whom may we thank for referring you_____

PRIMARY INSURANCE

Person Responsible for Account_____
Relation to Patient_____Birthdate_____Social Security #_____
Address (if different from patient)_____Home phone_____
City_____State_____Zip_____
Person Responsible Employed by_____Occupation_____
Business Address_____Business Phone_____
Dental Insurance Company_____Phone_____
Group #_____Subscriber ID_____
Names of other dependents under this plan_____

SECONDARY INSURANCE

Names of Person Responsible for Account_____
Relation to Patient_____Birthdate_____Social Security #_____
Address (if different from patient)_____Home phone_____
City_____State_____Zip_____
Person Responsible Employed by_____Occupation_____
Business Address_____Business Phone_____
Dental Insurance Company_____Phone_____
Group #_____Subscriber ID_____
Names of other dependents under this plan_____

MEDICAL HISTORY

Are you under a physician's care now? Yes No If yes, for what?_____
Physician's name_____Phone_____
Preferred Pharmacy_____
Have you even been hospitalized or had a major operation? Yes No If yes, for what?_____
Have you ever had a serious head or neck injury? Yes No
Do you take, or have you taken bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Didronel, Boniva)? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No If yes, what type and how often?_____
Do you use controlled substances? Yes No
Women: Are you Pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No
Have you ever been required to take antibiotic premedication prior to dental procedures? Yes No

Do you have, or have you had, any of the following? Please circle all that apply.

AIDS/HIV positive	Cortisone Medication	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problem	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease

Have you ever had any serious illness not listed above? Yes No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other_____

Are you currently taking any medications, vitamins or supplements? If yes, please list all:
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of patient, parent or guardian_____Date_____

DENTAL HISTORY

What brings you to our office today?_____
Previous dental office_____Date of last dental visit_____
Address_____Phone_____

Circle if you have had problems with any of the following:

Bad Breath	Bleeding gums	Sensitivity to cold
Sensitivity to hot	Periodontal treatment	Sores in mouth
Food collection between teeth	Grinding or clenching teeth	Sensitivity to sweets
Clicking or popping in jaw	Loose teeth or broken fillings	Sensitivity when biting

How often do you brush?_____Floss?_____
Are you happy with the appearance of your teeth?_____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?_____

GENERAL CONSENT TO PERFORM DENTISTRY

I hereby authorize any of the doctors at this facility and dental auxiliaries to proceed with and perform the dental procedures and treatments as have been explained to me. I understand that treatment can only be estimated and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

Signature of patient or parent if minor_____Date_____

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and treatment or examination rendered to me or my child during the period of such dental care to third party payers (insurance company) and/or other health practitioners. Email correspondence will be in encrypted format.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Whom do you authorize us to disclose account and treatment information_____

_____

Signature of patient or parent if minor_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____have received a copy of this office's Notice of Privacy Practices.

Signature_____Date_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (please specify) _____

FINANCIAL POLICY

We appreciate the opportunity to serve you! Please read the following carefully and ask us any questions you might have.

- **Patients without insurance coverage**
  The fee for treatment rendered must be paid in full on the day of service.
- **Patients with insurance coverage**
  The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all fees generated by your treatment.
- **We accept Cash, Checks, Visa, MasterCard and American Express**
  Payment plans are available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.
- **Two business days notice is required for rescheduling appointments**
  Appointments are reserved exclusively for you. Unless cancelled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit.

This is an agreement between Blair Ridge Dental, as creditor, and the patient/Debtor named on this form. By executing this agreement, you consent to treatment by Blair Ridge Dental and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name (Please print): _____

Responsible Party if patient is minor (Please print): _____

Signature of patient or parent if minor: _____ Date: _____

The Financial Policy continues on the back of this page.

Full payment is due at time of service: For your convenience we accept cash, checks, and credit cards (Visa, MasterCard, Discover, and American Express). We also offer Care Credit which is an extended payment plan with prior credit approval. A fee of $30 will be added to your account for any checks returned by your bank.

Patients with insurance coverage need to know: Insurance benefits are determined by your employer, not your dentist. Insurance is not a guarantee of payment; it may not cover all your costs. Your insurance policy is a contract between you and your insurance company. Payment to Blair Ridge Dental is ultimately your responsibility. As a courtesy we will be happy to file your claim for you. Please provide us with your dental insurance card and required employer information. If your insurance company has not paid your claim within 60 days after the date of service, the full amount is due and payable by you. We will promptly refund to you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage.

Third Party Financing Options: Care Credit, a patient financing company, and offers our patients 0% interest for 6, 12 and 18 months with approval.

Finance charges: A finance charge will be imposed on each item of your account which has not been paid within 60 days of the time the item was added to the account. The finance charge will be computed at a 1.5% monthly finance/interest charge.

Past due accounts: If your account becomes past due, we will take the necessary steps to collect this debt. This will negatively impact your credit history and limit the treatment you can receive at our office.

Emergency Patients new to our practice: Should expect to make a payment at the time of service. Once established as an active patient, we will be happy to offer additional payment options.

Payments: Unless Blair Ridge Dental approves other arrangements in writing, the balance on your statement is due and payable when a statement is issued, and is overdue if not paid by twenty-one (21) days after statement date.

Missed Appointments: Appointments are reserved exclusively for you. Unless cancelled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit.

Worker's Compensation: We do file worker's compensation claims. Please provide us the necessary claim forms and understand that if full payment is not received within 60 days you will be responsible for the balance.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Treatment Plans: Blair Ridge Dental will provide treatment recommendations for you. You will receive an itemized list of the recommended treatment. This will contain an estimate of the fees for the recommended treatment. If you have dental insurance, the treatment plan may include an additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. Please understand that treatment plan estimates are not a guarantee of insurance payment and you are ultimately responsible for all fees generated by your treatment.

Secondary Insurance Policies: Even if you have dual coverage (which is possible when you and your spouse both have insurance) there may still be a portion that is your responsibility. We file claims to many different insurance companies, and it is impossible for us to know what your insurance provider deems as a duplicating procedure or non-covered service.

Appointments involving lab work: All procedures involving lab work will require 50% down payment, then the remaining 50% balance will be due as treatment progresses. The balance must be paid before final insertion.