RENEW DENTAL

Name of Patient _____ **Birthdate** _____

Social Security No. _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Email Address _____

Mobile Phone _____ Work Phone _____ Pager _____

Employer _____ City _____ Occupation _____

Who referred you to this office? _____

Name of Parent/Partner/Spouse/Guardian _____ **Birthdate** _____
(circle one)

Social Security No. _____

Street Address (if different) _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Ext _____

Employer _____ City _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____
(other than spouse)

INSURANCE INFORMATION

Employee Name _____

INS CO Name _____

INS CO Address _____

INS CO City, ST Zip _____

Insurance Phone _____

Group/Policy # _____

Employee SSN _____

Birthdate _____

INSURANCE INFORMATION

Employee Name _____

INS CO Name _____

INS CO Address _____

INS CO City, ST Zip _____

Insurance Phone _____

Group/Policy # _____

Employee SSN _____

Birthdate _____

Patient Acknowledgments:

- I understand that I am responsible for any uninsured balance.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes
- If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical practitioner/provider for any needed evaluation.

I have read, and I agree to the above acknowledgments:

Signature of patient _____ Date _____
(parent or guardian, if patient is a minor)

RENEW DENTAL

NAME OF PATIENT _____ DATE OF BIRTH _____

NAME OF PHYSICIAN _____ PHYSICIAN'S PHONE _____

PHYSICIAN ADDRESS _____

REASON FOR VISIT _____ DATE OF MOST RECENT VISIT TO PHYSICIAN _____

To ensure your well-being while undergoing treatment in our office, please answer the following questions with a YES or NO response and provide <u>further details</u> for all YES responses. All information will be considered confidential and for our records only.

When was your last complete physical examination with your physician, including blood tests?

_____

Are you currently seeing a physician for treatment of a recent or ongoing medical condition? If yes, explain the condition.

YES NO

☐ ☐ _____

Have you been hospitalized or had any surgeries within the last two years? If yes, please explain:

YES NO

☐ ☐ _____

Have you ever been advised to take antibiotics (like Penicillin, etc.) prior to a dental appointment? If yes, please explain:

YES NO

☐ ☐ _____

Have you ever had any serious medical trouble associated with any dental experience? If yes, please explain:

YES NO

☐ ☐ _____

Do you have, OR have you had any of the following cardiovascular conditions? Please check all that apply:

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Coronary Bypass
- ☐ Angina
- ☐ Mitral Valve Prolapse
- ☐ Hardening of the Arteries
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Heart Murmur
- ☐ Shortness of Breath when lying down
- ☐ Chest Pain on Exertion
- ☐ Frequent or Unexpected Nose Bleeds
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Congestive Heart Failure
- ☐ Congenital Heart Defects
- ☐ Prosthetic Heart Valves
- ☐ Pacemaker: placement date: _____ Type: _____
- ☐ Surgically Implanted Defibrillator
- ☐ History of Infective Endocarditis
- ☐ Heart Transplant
- ☐ Shortness of Breath after Mild Exercise
- ☐ Swelling of the Ankles
- ☐ Abnormal Bleeding or Extended Clotting Time

Do you consider yourself to be under an abnormally high amount of stress?

YES NO

☐ ☐ _____

Do you OR have you ever smoked?

YES NO

☐ ☐ How much? _____ When did you quit? _____

Do you OR have you used chewing tobacco?

YES NO

☐ ☐ How often? _____

Do you drink alcohol OR have you in the past?

YES NO

☐ ☐ How much? _____

Do you have, OR have you had any of the following health conditions? Please check all that apply:

- ☐ Diabetes – Type: _____
- ☐ Artificial Joints – Which joints? _____
- ☐ Hepatitis – Which Type (A, B, or C)? _____
- ☐ Blood Transfusion – When? _____
- ☐ HIV
- ☐ Tuberculosis
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune Disease – Which? _____
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Sinus Problems
- ☐ Cirrhosis
- ☐ Depression
- ☐ Drug/Alcohol Treatment
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Herpes
- ☐ Hyperthyroidism
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Radiation Treatment
- ☐ Severe Headaches
- ☐ Sexually Transmitted Disease
- ☐ Skin Conditions
- ☐ Ulcers

ALL

Are you **ALLERGIC** to **ANY** of the following?

- ☐ Penicillin
- ☐ Sulfa
- ☐ Local Dental Anesthetics
- ☐ Codeine
- ☐ Sedatives
- ☐ Aspirin
- ☐ Other _____
- ☐ Nickel
- ☐ Latex
- ☐ Sulfites
- ☐ Barbiturates
- ☐ Tranquilizers
- ☐ Tetracycline

FEMALE REPRODUCTIVE SYSTEM

Yes No

- ☐ ☐ Are you pregnant?
  If so, expected delivery date? _____
- ☐ ☐ Do you have regular gynecological checkups?
- ☐ ☐ Have you reached menopause?
- ☐ ☐ Are you taking hormone replacement?
- ☐ ☐ Have you had a mammogram? Date: _____

Have you ever had an **ADVERSE REACTION** to **ANY** drug or medication? If yes, indicate medication and reaction:

YES NO

☐ ☐ _____

Do you have **ANY** disease, condition or medical problem **NOT LISTED** on this form? If yes, please indicate the condition:

YES NO

☐ ☐ _____

Please indicate if you are currently taking ANY of the following listed medications OR if you have taken any of these medications within the past year. Please check all that apply:

- ☐ Antibiotics
- ☐ Antidepressants (Prozac, Zoloft, Etc.)
- ☐ Antihistamines
- ☐ Blood Pressure Medication
- ☐ Blood Thinners
- ☐ Cortisone (Prednisone)
- ☐ Cholesterol Medication
- ☐ Decongestants
- ☐ Diuretics (water pills)
- ☐ Hormones (birth control, estrogen)
- ☐ Inhalants
- ☐ Insulin
- ☐ Heart Medication/Nitroglycerine
- ☐ Muscle Relaxants
- ☐ Pain Medication (Aspirin, Tylenol, Advil)
- ☐ Sleeping Pills
- ☐ Thyroid Medication
- ☐ Tranquilizers
- ☐ Vitamins
- ☐ *Copy of medications provided*

Please list your current medications if you have not provided a copy:

_____

_____

_____ _____

Patient Signature Date

RENEW DENTAL

Patient Rights and Responsibilities

Welcome to Renew Dental! Your dentist or dental specialist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect our doctors & dental staff and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

Patient Rights

1. You have a right to choose your own dentist and schedule an appointment in a timely manner.
2. You have a right to know the education and training of your dentist and the dental care team.
3. You have a right to arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. You have a right to adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. You have the right to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
6. You have a right to an explanation of the purpose, probable (short and long term) results, alternatives and risks involved before consenting to a proposed treatment plan.
7. You have a right to be informed of continuing heath care needs.
8. You have a right to know in advance the expected cost of treatment.
9. You have a right to accept, defer or decline any part of your treatment recommendations.
10. You have a right to reasonable arrangements for dental care and emergency treatment.
11. You have a right to receive considerate, respectful and confidential treatment by your dentist and dental team.
12. You have a right to expect the dental team members to use appropriate infection and sterilization controls
13. You have a right to inquire about the availability of processes to mediate disputes about your treatment.

Patient Responsibilities

1. You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.
2. You have the responsibility to report changes in your medical status and provide feedback about your needs and expectations.
3. You have the responsibility to participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.
4. You have the responsibility to inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.
5. You have the responsibility for consequences resulting from declining treatment or from not following the agreed upon treatment plan.
6. You have the responsibility to keep your scheduled appointments.
7. You have the responsibility to be available for treatment upon reasonable notice.
8. You have the responsibility to adhere to regular home oral health care recommendations.
9. You have the responsibility to assure that your financial obligations for health care received are fulfilled.

_____ I have read and understand the above Patient Rights and Responsibilities, and I agree to abide by these guidelines.
Initials

Printed Name

Today's Date

Signature

RENEW DENTAL

Cancellation, No Show, Missed Appointment & Late Arrival Policy

Patient's Name: _____ Date of Birth: _____
(Printed) Last First

Renew Dental, PLLC is committed to providing all our patients with exceptional care. When patients cancel without giving enough notice, they prevent another patient from being seen.

A "No-Show" or "Missed" appointment is when any scheduled appointment in which the patient either:

- Does not arrive for the appointment
- Cancels under the policy notice for the appointment
- Arrives more than 15 minutes late for the scheduled appointment

Our office will attempt to contact you two (or five) business days prior to your scheduled appointment as a courtesy to remind you of your appointment. We would appreciate a call back to confirm your appointment.

Office Visit (1 hour or less) – requires **two (2) business days prior** to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday*** appointment, please **call our office by 12:00PM on *Wednesday*** the week before.

Extensive Office Procedure (more than 1 hour) – requires **five (5) business days prior** to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday*** appointment, please **call our office by 12:00PM on *Monday*** the week before.

If the proper notification is not given within the timeframes stated above, you will be charged **$200 per hour scheduled** for the missed appointments; this will not be covered by your insurance company.

We will require that patients pay their balance prior to receiving further care and being rescheduled in our office. Patients with a balance over $200 must make payment arrangements prior to rescheduling.

I prefer to be reminded by:

- ☐ text preferred mobile number _____
- ☐ email preferred email address _____
- ☐ phone call preferred phone number _____
- ☐ I prefer not to be reminded and understand that a fee will be imposed/assessed if I miss my appointment

Please indicate your understanding of this policy as described above by signing below.

Signed: _____ Date: _____
Patient

Parent/Legal Guardian (Guarantor of Payment)

Relationship to Patient: _____

Name (printed): _____

Signed: _____ Date: _____

Staff: _____

RENEW DENTAL

Financial Policy

Patient's Name: _____ Date of Birth: _____
(Printed) Last First

Payment for services, including deductibles and copayments, is due at time of service unless other arrangements have been made prior to treatment. Payments may be made using cash, check, or credit cards (Visa or MasterCard only). Any arrangements for third party financing must be made before starting treatment.

Renew Dental, PLLC accepts all dental PPO plans and is a provider of Delta Dental insurance plans. We are happy to submit the claims necessary to see that you receive your benefits. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed. The insurance contract is an agreement between you and/or your employer and their insurance company. You are ultimately responsible for all charges.

We can provide estimates for our cost of services after the comprehensive exam. Predetermination of benefits with insurance benefit plans may be advisable if there is a question concerning coverage. This can take 2-4 weeks dependent on your insurance carrier.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered. You are responsible for payment of all services regardless of the payable benefit.

Nonpayment, payment reversal, or default of the terms agreed upon in a signed financial agreement will be assessed any bank fees, legal fees, and collection costs incurred including attorney fees. Any unpaid amounts remaining on your account shall after 30 days be sent to collections.

Checks that are returned to our office from your financial institution are subject to a $25 returned check fee. This fee covers administrative fees and the processing fees that are charged to our office. We would be happy to discuss our charges and how they relate to your particular situation.

Please indicate your understanding and acceptance of these financial policies by signing below.

Signed: _____ Date: _____
Patient

Parent/Legal Guardian (Guarantor of Payment)

Relationship to Patient: _____

Name (printed): _____

Signed: _____ Date: _____

Staff: _____

RENEW DENTAL

RECEIPT OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify Below)

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