Apex Dental Studio

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender:_____ Family Status:_____

How did you hear about our office?
☐ Friend/Family member name _____ ☐ TV commercial ☐ Radio ☐ Mailer ☐ Online ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ Text Reminders OK? ☐ Yes ☐ No
E Mail: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th ☐F ☐S

Address:

_____
Street Apartment #

_____
City State Zip Code

Health History

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

- ☐ Allergies (seasonal/food) _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/ Anxiousness
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other (please list)
- ☐ _____ _____ _____ _____

For WOMEN Only

- ☐ Birth Control Pills
- ☐ Breast-Feeding
- ☐ Currently Pregnant
  - ☐ 1-3 mos
  - ☐ 3-6 mos
  - ☐ 6-9 mos

If pregnant, what is the name of your OB/GYN?
_____
Ph. #_____

Allergies

- ☐ Nickel
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Codeine
- ☐ Other: _____

Are you taking any blood thinning medications?

- ☐ Yes
- ☐ No

Please list all medications that you are taking including any anticoagulants (blood thinning medications):

_____

_____

Are you currently under the care of a Pain Management specialist? ☐ Yes ☐ No
If yes, please explain:

_____
Name of Physician: _____ Phone: _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Pharmacy of choice: City: Phone Number:

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:
_____

Dental History

Date of Last Dental Visit: _____

Reason for today's dental visit: _____

Please check any of the following dental problems that may apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped, or shifted teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Gum Disease Treatment
- ☐ Jaw surgery
- ☐ Wisdom teeth removal

Name of Previous Dentist:
_____

City:_____ State: _____
Phone Number: _____

What is the most important thing to you about your future smile and dental health?
_____

If you could whiten your teeth for a cost anyone could afford, would you do it?
_____

Do you smoke or use chewing tobacco? How much and for how long?
_____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:
How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all copayments. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. 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. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

HIPAA PATIENT CONSENT FORM

I understand that, under the 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 physicians' certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above 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 healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____ Date: _____/_____/_____

Signature: _____

Relationship to Patient: _____

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I hereby authorize the staff of Apex Dental Studio to discuss any necessary medical and billing information on my behalf with the following individual(s);

Name	DOB	Relationship	Phone #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Digital Communications Acknowledgement

I understand that Apex Dental Studio uploads and stores confidential information (including account information, appointment information and clinical information) to a secured dental system. I also understand that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice cannot and does not assume any responsibility for my use or misuse of patient information or other information transmitted, monitored, stored, uploaded, or received using the site or the services.

My signature below acknowledges that I understand Apex Dental Studio uses digital communications for my personal data.

Patient or Guardian Signature: _____ Date: _____

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, cashier's checks, money orders, Visa, Mastercard, Discover, American Express and CareCredit. Outside financing is available upon request and approval. ***We do not accept personal checks effective February 1, 2019.***

☐ **Please check here if you are interested in more information about financing options.**
**Please note that all financing options are contracted with third party companies. All charges you incur are your responsibility. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your financing company. Our office will not enter a dispute over any financial arrangements with third parties.*

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer or State of Indiana, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing you the best treatment for our patients and we charge what is usual and customary for our area, unless we share direct network affiliation with separate contracted fees. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, Visa, Mastercard, Discover, American Express or CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, our office will not enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

CANCELLATIONS, LATE ARRIVALS and NO SHOWS

CANCELLATION OF AN APPOINTMENT:

In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. Please inform us at least a minimum of 24 hours in advance if you are unable to keep your appointment.

LATE ARRIVALS:

If you are more than 15 minutes late, we will need to shorten or reschedule your appointment if time does not permit.

NO SHOW POLICY:

A no show is an appointment that was not canceled in-advance. No shows inconvenience other patients who need dental care and leave the doctor and staff idle. A broken appointment is a loss to everyone.

As a courtesy, we do not charge a fee for late cancellations or no shows at this time. ***However, if three or more appointments are missed or cancelled without 24-hour notice, we reserve the right to no longer schedule additional appointments. For families scheduling 3 or more patients same day, we allow no more than one broken set of appointments.*** *Any future visits will be scheduled one patient at a time, following the above guidelines.*

Thank you for your cooperation.

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I have read and acknowledged the above policy;

_____	_____
Patient Name (printed)	Relationship to Patient
_____	_____
Signature of patient, parent, or guardian	Date