WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

1 ABOUT YOU

Name _____

Preferred Name _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthday _____ Age ____ SS # _____

Address _____

City _____ State _____ Zip _____

Email _____

Home # _____ Work # _____

Mobile # _____ Fax # _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Last visit date _____

Employer _____ Employer Ph.# _____

Employer Address _____

How long employed there? _____

SPOUSE INFO

Name _____

Home # _____ Work # _____

Mobile # Birthdate _____

Email _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home # _____ Work # _____

Mobile # _____ Birthdate _____

Email _____

Billing Address _____

City _____ State _____ Zip _____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us. We are happy to help.

3 INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Phone # _____

Group # _____

ID # _____

Insured's Birthdate _____

Insured's Employer _____

Insured's Ph # _____

Insured's SS # _____

**ID# is sometimes different than SS#*

IF YOU HAVE A SECONDARY INSURANCE PLEASE LET A TEAM MEMBER KNOW.

4 REMINDER INFO

Because we know your life is busy, we use an electronic appointment reminder and messaging system. Please check all that you prefer, as our best way to contact you.

❑ Email Only ❑ Text Message Only ❑ Text Message & Email

5 REMINDER INFO

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____

Home # _____ Work # _____

Name on Credit Card: _____

Credit Card #: _____ **Authorization Code:** _____

Expiration Date: _____ **Credit Type (MC/Visa/Discover/Amex):** _____

To be used for Services not covered by Insurance

6 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone # _____ Last visit date _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain _____

_____

Your current physical condition Good Fair Poor

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

_____

_____

Have you ever taken Phen-Fen? ☐ Yes ☐ No

(Also known as Redux or Pondimin) If yes, when? _____

Are you taking any medications for Osteoporosis? ☐ Yes ☐ No

If so, what? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	Yes No	Erythromycin	Yes No	Penicillin	Yes No
Codeine	Yes No	Jewelry / Metals	Yes No	Tetracycline	Yes No
Dental Anesthetics	Yes No	Latex	Yes No	Other	Yes No

Please list any other drugs / metarials that you are allergic to:

_____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal Bleeding	Yes No	Herpes / Fever Blisters	Yes No		
Alcohol / Drug Abuse	Yes No	High Blood Pressure	Yes No		
Anemia	Yes No	HIV+ / AIDS	Yes No		
Arthritis	Yes No	Hospitalized for any reason	Yes No		
Artificial Bones, Joints, or Valves	Yes No	Kidney Problems	Yes No		
Asthma	Yes No	Liver Disease	Yes No		
Blood Transfusion	Yes No	Low Blood Pressure	Yes No		
Cancer / Chemotherapy	Yes No	Lupus	Yes No		
Colitis	Yes No	Mitral Valve Prolapse	Yes No		
Congenital Heart Defect	Yes No	Pacemaker	Yes No		
Diabetes	Yes No	Psychiatric Problems	Yes No		
Difficulty Breathing	Yes No	Radiation Treatment	Yes No		
Emphysema	Yes No	Rheumatic / Scarlet Fever	Yes No		
Epilepsy	Yes No	Seizures	Yes No		
Fainting Spells	Yes No	Shingles	Yes No		
Frequent Headaches	Yes No	Sickle Cell Disease	Yes No		
Glaucoma	Yes No	Sinus Problems	Yes No		
Hay Fever	Yes No	Stroke	Yes No		
Heart Attack	Yes No	Thyroid Problems	Yes No		
Heart Murmur	Yes No	Tuberculosis (TB)	Yes No		
Heart Surgery	Yes No	Ulcers	Yes No		
Hemophilia	Yes No	Venereal Disease	Yes No		
Hepatitis	Yes No				

Please list any medical condition(s) that you have ever had:

_____

_____

MEDICAL HISTORY CONT.

Do you have trouble sleeping? ☐ Yes ☐ No

Do you feel tired or fatigued after sleep? ☐ Yes ☐ No

Do you feel like you get enough sleep at night? ☐ Yes ☐ No

Do you have a CPAP? ☐ Yes ☐ No

If so, do you wear it? ☐ Yes ☐ No

FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

7 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Has your doctor told you that you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is Good Fair Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many time a day do you brush? _____

Type of toothbrush bristles? Hard Medium Soft

8 DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees, and court costs.

_____

Signature Date

_____

Print

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE & CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

I may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

_____ _____
Printed Name Signature

Dependents:
_____

How would you like to be addressed when summoned from the reception area:
{ } First name only { } Proper sir name { } Other:_____

Please list any other parties who can have access to your health information:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I authorized Deerfield Family Dentistry to confirm my appointments, treatment and billing information via:
{ } cell phone { } text message { } home phone
{ } work phone confirmation { } email confirmation { } any of the above

I authorize information about my health be conveyed via:
{ } cell phone { } text message { } home phone
{ } work phone confirmation { } email confirmation { } any of the above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote you improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule provide you this information with your knowledge and consent.

Office use only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
{ } Emergency treatment { } I could not communicate with the patient

{ } The patient was unable to sign because:_____

{ } Other:_____

DEERFIELD FAMILY DENTISTRY PLLC

Deerfield Family Dentistry

Financial Policy

Thank you for choosing our office as your dental health care provider. Our office provides quality, comprehensive dentistry to our patients. In return, our patients are responsible to us for their financial obligation. Insurance benefits are a terrific aid in helping to fulfill those obligations. We are a Delta Premier Provider. Our office will assist you at no charge in securing the maximum insurance benefits you are entitled to. **IT IS NOT OUR RESPONSIBILITY NOR OUR INTENT TO ACT AS MEDIATOR BETWEEN YOU AND YOUR INSURANCE COMPANY.** Your insurance policy is a contract between you, your employer, and your insurance company. **IT IS YOUR RESPONSIBILITY TO MONITOR YOUR REMAINING BENEFITS AVAILABLE** so as to not unexpectedly run over the maximum.

We ask that you pay your portion on the day of services. We accept cash, checks, MasterCard, Visa, American Express, and Discover cards. There is a fee of $25 for any returned checks. **WE DO NOT ACCEPT MONTLY PAYMENT PLANS.** Most insurance companies will reimburse patients within two weeks. If your insurance carrier has not paid their portion within 60 days of the date of service, that balance now becomes your responsibility also.

Any balance unpaid after 30 days is subject to an interest rate of 10%. Be aware that your failure to keep your account current may result in Deerfield Family Dentistry being unable to provide additional dental services except for dental emergencies. In case of default on payment of this account, you will be charged the collections costs and reasonable fees incurred in attempting to collect on this amount or any future outstanding account.

Due to staffing requirements, for your visit there will be a charge of $75.00 for any missed appointments. If unable to keep an appointment, 72 hours notice is required to avoid this fee.

We offer 5% senior citizen discount to our patients 65 years young.

We offer discounts for payments made before your scheduled appointment.

We also offer Care Credit, which is an extended financing solution to include up to 12 months of interest free loans.

By signing, you are also authorizing release of any medical or other information necessary to process a claim. You are also authorizing payment of benefits for services rendered to either Dr. Pike or the subscriber according to the policy of her practice.

The undersigned herby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment of Dental Services provided in this office for myself or my dependents is mine. I further understand that a finance charge or any fees associated with collection of an overdue account will be added to any overdue balance. I hereby authorize this office to obtain a credit report from a credit reporting agency for the purpose of considering payment options.

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

Patient/Guardian Signature _____ Date _____

I have been offered copies of Dr. Pike's "Notice of Privacy Practices" and the Dental Restorative Materials Fact Sheet and have been given the opportunity to ask any questions that I may have regarding these "Notices".

Patient/Guardian Signature _____ Date _____

*some restrictions may apply