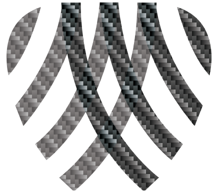

preston dental loft

Thank you for the opportunity to evaluate your dental condition. In order to provide the best service for you, please complete the following information.

About You

Last Name:______________________ First Name:______________________

Address:______________________

City:______________________ State:__________ Zip:______________

Home #:______________ Work #:______________ Mobile #:______________

Email:______________________ Gender:__________ SS#:______________

DOB:______________ Marital Status:______________ Employer:______________

Who may we thank for referring you?:______________________

Responsible Party ❑ Same as above

Last Name:______________________ First Name:______________________

DOB:______________________ SSN#:______________________

Employer:______________________ Work #:______________________

Insurance Information

Insurance Company:______________________ ID#:______________________

Claims Address:______________________

City:______________________ State:__________ Zip:______________

Phone:______________________ Group #:______________________

Policy Holder:______________ DOB:__________ Relationship to patient:______________

Group Name/Employer:______________________

Additional Insurance Information

Secondary Dental Plan:______________________ Group#:______________________

Policy Holder:______________________ DOB:______________________

Group Name/Employer:______________________ SSN:______________________

Dental Health

What is your immediate concern? ____
____
____

Please select any of the following that apply to you:

Personal History

Are you fearful of dental treatment?
Have you had an unfavorable dental experience?
Have you ever had complications from past dental treatment?
Have you ever had trouble getting numb or had reactions to local anesthetic?
Did you ever have braces, orthodontic treatment or had your bite adjusted?
Have you had any teeth removed?

Gums & Bone

Do your gums bleed or are they painful when brushing or flossing?
Have you ever been treated for gum disease or been told you have lost bone around your teeth?
Have you ever noticed an unpleasant taste or odor in your mouth?
Is there anyone with a history of periodontal disease in your family?
Have you ever experienced gum recession?
Have you ever had any teeth become loose on their own (without injury)?
Have you experienced a burning sensation in your mouth?

Tooth Structure

Have you had any cavities within the past three years?
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?
Do you feel or notice any holes on the biting surface of your teeth?
Are your teeth sensitive to hot, cold, biting, sweets or brushing?
Do you have grooves or notches on your teeth near the gum line?
Have you ever broken teeth, chipped teeth or had a toothache or cracked filling?
Do you frequently get food caught between any teeth?

Bite & Jaw Joint

Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
Do you feel like your lower jaw is being pushed back when you bite your teeth together?
Do you avoid or have difficulty chewing gum, carrots, nuts or other hard foods?
Have your teeth changed in the last 5 years, become shorter, thinner or worn?
Are your teeth crowding or developing spaces?
Do you have more than one bite and have to squeeze to make your teeth fit together?
Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?
Do you clench your teeth in the day time or make them sore?
Do you have any problems with sleep or wake up with an awareness of your teeth?
Do you wear or have you ever worn a bite appliance?

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change?
Have you ever whitened (bleached) your teeth?
Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?
Have you ever been disappointed with the appearance of previous dental work?

Please use the space below to indicate any other problems, concerns or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options.

____

____

____

Medical Health

Name of Physician:____

Have you been under the care of a physician in the past 2 years? No Yes if yes, why?____________________

____

Have you been treated in a hospital in the past 2 years? No Yes if yes, why?______________________

____

Are you now or have you taken any prescription drugs during the past year? If so, please list.

____

Do you use tobacco products?____

Have you ever been told that you need antibiotics prior to dental treatment?______________________

Are you allergic or sensitive to any medication? ____

Indicate which of the following you have had, or have at present.

Heart disease	Angina	Jaundice	HIV
Arthritis	Kidney Disease	Diabetes	Artificial Heart Valves
Liver Disease	Heart Murmur	Artificial Joints	Organ Transplant
Hepatitis	Asthma	Pacemaker	Pregnant
Cancer	Polio	Prolonged Bleeding	Chemotherapy
Cough	Rheumatic Fever	Congenital Heart Issue	Psychiatric Treatment
Stroke	Drug Dependence	Radiation Therapy	Tuberculosis
Epilepsy	Sickle Cell Anemia	Fainting	Abnormal Blood Pressure
Thyroid Disease	Allergies	Glaucoma	Ulcers/Acid Reflux
Anemia	Herpes	Venereal Disease	Sleep Apnea

Do you have any diseases, conditions, or problems not previously listed?____________________________

____

Have you recently used illegal drugs? No Yes If yes, please list:__________________________________

Sleep Apnea

The following survey has been provided to aid you in diagnosing and curing issues which might be related to snoring, upper air resistance and sleep apnea.

Please enter the number of your condition during the following activities.

0= Would never doze   1= Slight chance of dozing   2= Moderate chance of dozing   3= High chance of dozing

1. Sitting and reading ______
2. Watching television ______
3. Sitting inactively in a public place ______
4. As a passenger in a car for an hour without break. ______
5. Lying down to rest in the afternoon. ______
6. Sitting and talking to someone. ______
7. Sitting quietly after lunch without alcohol. ______
8. Driving a car stopped in traffic or at a stop light. ______
9. Have you ever been told you snore? YES NO
10. Do you wake up feeling fatigued? YES NO
11. Do you have morning headaches? YES NO
12. Have you been diagnosed with chronic fatigue syndrome, fibromyalgia, or TMJ YES NO
13. Any additional comments that may be helpful? ____

____

I hereby authorize Dr. Meenal Patel to perform procedures, including but not limited to: giving local anesthetic and medications; making radiographs and photographs to be used in professional presentations; performing head & neck examination; restoring teeth; any necessary restorative therapy. I certify that I have read and fully understand the above and consent to treatment. I authorize the release of any information necessary to process my insurance claim and also hereby authorize payment of insurance benefits to Meenal Patel, DMD. A copy of this signature is valid as the original. Your name and signature indicate that you have received a copy of our Notice of Privacy Practices on the date indicated.

Signature:____

Date:______________________

Emergency Name & Contact #:____

Financial Policy

At Preston Dental Loft we want all of our clients to be able to comfortably afford dental care. We proudly ofer the following financial policies so that our clients have the opportunity to decide which payment option is best for their needs.

Insurance: Your insurance is a contract between you, your employer, and your insurance company. Preston Dental Loft will gladly work with you to help you get the maximum benefit available to you. Most insurance plans do not cover 100% of the treatment cost. Because of this, we ask that you pay your deductible as well as your ESTIMATE co-pay for the charges on the day services are rendered. We will estimate your coverage as closely as possible, but can make no guarantees as to what your insurance will pay. We understand that dental benefits are important to our clients. After all treatment, we will promptly file and follow up on your dental claims to ensure that your receive the correct maximum benefits. We offer several financial options for your portion of diagnosed treatment so that your care is not compromised due to financial concerns.

Payment Options

1. Cash or Check (There is a $25 fee for all returned checks)
2. MasterCard, Visa, Discover, or American Express
3. Care Credit: A convenient line of credit can be arranged, on approval, for your health care needs. Interest-free plans are available.

Our Appointment Policy

Because we reserve time specifically for you, it is vital that we receive appropriate notice for cancellations. If you find that you are unable to keep an appointment, please call our office 24 hours in advance. Appointments not cancelled within 24 hours, or no-show appointments will be charged a $50 fee.

For larger, more extensive appointments, a 20% reservation fee will be collected at the time the appointment is reserved. This amount collected will be put towards your treatment balance. We understand that circumstances may arise when an appointment may need to be rescheduled. Please make all attempts to do so within 24 hours. Unfortunately, due to expenses we acquire in preparing for your larger cases, the 20% cannot be returned if the appointment has to be cancelled and not rescheduled.

Financial Responsibility

I understand that payment is due at the time of service unless prior arrangements have been made. I understand that my insurance may cover a portion of the treatment; however, I am ultimately responsible for any balance on my account for services rendered.

I have read and fully understand the financial policies of this office.

Signature:________________________________

Date:___________________________________

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

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

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________________ ______________________________
Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

______________________________ ______________________________
Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ____________________________________
____

HOW DO YOU WANT 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:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ____________________________

Name: ________________________ Relationship: ____________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone 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 your 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:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____ ______________________________

Signature of Privacy Officer