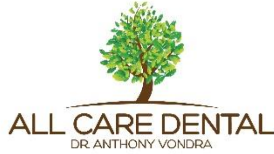

New Dental technology and trends make dental visits more comfortable and enjoyable. Select "YES" or "NO" enabling our oral health care team to be sensitive to your dental needs and concerns. Our goal is to provide a great dental experience for you.

Patient Name__________________________ Date of Birth______________________

Whom may we thank for referring you to our practice? ___ Another patient, friend
___Another Patient, relative ___Valpak ___ Another Dental Office ___Mobile Device
___Facebook ___Google Search ___Insurance Website ___Other
Name of Person or office referring you to our practice: ___________________________

Brushing and Flossing

- Are you currently using a manual toothbrush? YES NO
- Do you feel you could do a better job cleaning between your teeth? YES NO
- Are your teeth Sensitive? YES NO
- Do your gum tissues bleed? YES NO
- Is the prevention of gum disease periodontitis or gingivitis a concern? YES NO

Clenching and Grinding
1. Do you grind your teeth and do they show wear? YES NO
2. Are you bothered by persistent headaches or migraine attacks? YES NO

Whitening and cosmetic Improvements
1. Would you like to whiten or brighten your current tooth shade? YES NO
2. Have you used whitening products or procedures? YES NO
3. Have you considered improving your smile with cosmetic dentistry? YES NO

Invisible Braces
1. Would you like to know more about Invisalign? YES NO
2. Have you experienced minor teeth shifting after having worn braces? YES NO

Sedation Dentistry
1. What level of anxiety do you experience with dental visits?

None at all Some what anxious Highly anxious Extreme Anxiety

Do your fears of dentistry keep you from completing needed dental work? YES NO
Would you like to know more about the various levels of sedation dentistry? YES NO

Last but not least, if you could change something about your smile, what would that be?
____

____

Patient HIPAA Consent Form and Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right 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 physician 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 the 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 *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 health care operations. I also understand you are not required to agree to my requested restrictions, 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: ________________________________

Signature: __________________________________

Relationship to Patient: ________________________

Date: ____________

Staying within the "reasonable" guidelines of HIPAA, I give permission for All Care Dental to discuss my dental care and related issues with the following persons, in addition to myself. If none, please state so:

Name: Relationship:

____

____

____

Email and Text Messaging Program Patient Information Form

We provide our patients the option to participate in our online patient communication system.

Some of the system features allow you the ability to:

- **Request Appointments via Email**
- **Confirm Appointments via Email**
- **Receive Text Message Appointment Reminders**
- **Submit Patient Satisfaction Surveys**
- **Refer Your Friends Online**

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email, or by replying to a text message with 'STOP'. Standard text messaging rates apply.

Please Update Your Contact Information

Name: ______________________________

Address: ______________________________

City: ______________________________

State: ______________________________

Zip: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

Email: ______________________________

Birthday: ______________________________

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for All Care Dental in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Please sign below to indicate that you agree to allow us to use this information in providing your services.

____

Signature **Date**

All Care Dental
FINANCIAL POLICIES

1. **Payments**: The patient portion, amount not covered by insurance, for all dental services performed must be paid in full at the time of treatment, unless prior arrangements have been approved.

2. **Dental Insurance**: All dental services performed are charged directly to insurance and you are personally responsible for percentages not paid. Our office will assist in preparing and submitting insurance claims and reasonably assist in making collections from insurance companies. We will apply any such insurance payments to your account. However, all insurance payments are **ESTIMATES** only. **We do not guarantee any payments by an insurance company** for dental services rendered by All Care Dental. Any and all amounts not paid by the insurance company for dental services are your responsibility.

3. **Cancellation Policy**: We reserve the right to charge a **$30.00** fee for missed appointments that are not cancelled at least **48 business hours** in advance.

4. **Unpaid Balances**: Please provide a credit card number to transfer any and all unpaid balances that are 90 or more days past due. If there are not prior arrangements made, by signing this agreement you understand and agree that our office will be billing your credit card for the entire balance due on the billing date.

Type of Card: (circle one) Visa Master Card Discover Care Credit
Name on card: ____
Account number: ____
CVV (3 Digit Code on back of card) _____________ Exp. Date________________

I have completed the form and have read the above financial and insurance policies and agree to same.

__________________________________ **Date**______________________
Patient, parent or guardian's signature

____
Relationship to patient

Are you covered by Medicaid? Yes No

If yes, I understand neither party can file a claim to Medicaid. ______
(Initials)

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)?
Yes No

ASSIGNMENT OF BENEFITS

I, ____________________________, do hereby authorize my insurance company to directly pay All Care Dental all insurance benefits otherwise payable to me for dental services rendered.

____________________________________ **Date**: _______________________
Signature