How did you hear about the office:________________

New Age Dental

PATIENT HEALTH HISTORY & INFORMATION

NAME: ______________________ (LAST) ______________________ (FIRST) **SEX:** M / F **MARITIAL STATUS:** Single / Married / Divorced / Other

ADDRESS (HOME): ____________ (STREET) ____________ (CITY) ____________ (ZIP) **HOME PHONE #:** ( ) ____________

DATE OF BIRTH: ____________ **SOCIAL SECURITY#:** ____________ **DRIVERS LICENSE#:** ____________

WORK PHONE#: ( ) ____________ **CELL #:** ( ) ____________ **EMAIL:** ____________

EMPLOYER: ____________ **City and State:** ____________ **Occupation:** ____________

PREFERRED METHOD OF CONTACT? (CIRCLE) HOME # CELL # WORK # EMAIL TEXTS

Spouses Name: ____________ Social Security#: ____________ Date of Birth: ____________

Identification #: ____________ Phone #: ( ) ____________ Employer: ____________

Work phone #: ( ) ____________

**Nearest Relative in area (not living with you)____________ Phone #: ( ) ____________

Who can we thank for referring you to this office? ____________

INSURANCE INFORMATION

Subscriber Name: ____________ **Home and/or Cell #:** ( ) ____________

Name of Insurance Company ____________ **Policy/Group#:** ____________

Subscribers Employer: ____________ **Work #:** ( ) ____________

Social Security#: ____________ **Date of Birth:** ____________

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or qualified designate. I have received a copy of the **Dental Materials Fact Sheet** as required by law. I also acknowledge full responsibility for my payment and agree to pay, in full, **AT THE TIME OF SERVICE**, unless other arrangements are made with the Financial Department.

Signed____________ **(Patient, Parent or Guardian (Must be 18 years or older)**

MEDICAL / DENTAL HISTORY

Physician's Name:____________ City/State____________ Phone#: ( ) ____________

When did you last consult a physician?____________ Reason:____________

Have you been hospitalized or have had any surgeries within the past 5 years: ☐ Yes ☐ No Reason:____________

Name of former dentist:____________ Date of last dental examination:____________

Purpose of today's visit: ☐ complete examination ☐ pain ☐ broken tooth ☐ other ____________

Do you have, or did you have any of the following: (please check and describe fully under remarks):

	YES	NO		YES	NO		YES	NO		YES	NO
1. Heart Disease	☐	☐	11. Psychiatric Treatment	☐	☐	21. Allergies	☐	☐	29. Cancer	☐	☐
2. High Blood Pressure	☐	☐	12. Arthritis	☐	☐	a. medications	☐	☐	30. Osteoporosis	☐	☐
3. Blood disorder - anemia	☐	☐	13. Tumor History	☐	☐	b. latex	☐	☐	a. Bisphosphonates	☐	☐
4. Rheumatic Fever	☐	☐	14. Venereal Disease	☐	☐	22. Asthma	☐	☐	b. Fosamax	☐	☐
5. Heart Murmur	☐	☐	15. Sinus Trouble	☐	☐	23. Tuberculosis, emphysema	☐	☐	c. Boniva	☐	☐
6. Thyroid disease, hyperthyroidism	☐	☐	16. Ulcers	☐	☐	24. Artificial Joints	☐	☐	d. Actonel	☐	☐
7. Diabetes	☐	☐	17. Radiation Treatment	☐	☐	25. History of Phen Phen	☐	☐	31. TMJ	☐	☐
8. Stroke	☐	☐	18. Liver or Kidney Disease	☐	☐	26. Pacemaker	☐	☐			
9. Epilepsy	☐	☐	19. Hepatitis, Jaundice	☐	☐	27. Are you pregnant?	☐	☐			
10. Fainting	☐	☐	20. AIDS/HIV +	☐	☐	28. Do you smoke or drink alcohol?	☐	☐			

Have you had excessive bleeding requiring treatment? ☐ yes ☐ no

Are you taking any medicines, drugs, or pills? ☐ yes ☐ no

Have you experienced any unfavorable reaction to previous dental treatment? ☐ yes ☐ no

Do you have any disease, condition or problem not listed above that you think I should know about? ____________

Do you take ASPIRIN or any blood thinners daily? ☐ yes ☐ no

Patient Signature:____________ Date:____________ Doctor Signature:____________ Date:____________

Patient Signature:____________ Date:____________ Doctor Signature:____________ Date:____________

Patient Signature:____________ Date:____________ Doctor Signature:____________ Date:____________

Patient Signature:____________ Date:____________ Doctor Signature:____________ Date:____________

GENERAL DENTISTRY INFORMED CONSENT

OFFICE/PATIENT #____/________________ NAME__________________________

WORK TO BE DONE: I understand I am having the following done: Exam/Xray —, Fillings —, Crown —,Implant Bridge —, Dentures —, Root Canals —, Extractions —, Crown lengthening —, Bleaching —, Periodontal cleaning
DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics, sedative can cause allergic reactions causing redness, swelling , pain, itching, vomiting, shock, dizziness, numbness, mood swings, cardiac arrests, etc.(Initials —)
CHANGES IN TREATMENT PLAN: It may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination ex. root canal following filling/crown (prolonged sensitivity),or extraction (decay) I give permission to the dentist to make all changes &additions necessary.(Initials —)
ORTHODONTICS: No guarantees have been made to me regarding perfect orthodontic results. It may not be possible to fully align all teeth, close all gaps, or achieve perfect over-bite or expansion of arches. Further restoration may be necessary for desired results. I understand lack of proper (home) hygiene & missed ortho. appointments are causes for early termination of treatment that are non-refundable, and the dentist is not held responsible. (Initials—)
EXAM AND X-RAYS: I agree to inform the staff (prior to radiation) if I am pregnant, have cardiac pacemaker, cancer artificial prosthesis, etc. which would make X-rays or any other dental work hazardous to my health .(Initial-
FILLINGS: I have been advised by the dentist that although silver filling is accepted by ADA ,it may be harmful to your health. Advantages/disadvantages of alternate material has been explained. I understand fillings may fall off due to decay and poor oral hygiene, and occasionally teeth may get sensitive and require root canal therapy. (Initials —)
CROWNS, BRIDGES, VENEERS, DENTURES: I understand it is not possible to match the color, shape, translucency of natural teeth with artificial teeth . I may be wearing temp. caps which may come off easily, and must be careful to keep them on until the permanent ones are delivered. I understand that plastic or porcelain can fracture upon chewing in such case I would be responsible for the replacement cost. I realize the final opportunity to make changes in my new crown, veneer (shape, fit, size, color) will be before cementation, or at "teeth in wax"try-in visit for dentures after which I would be responsible for the cost of all changes. Permanent crowns can come off and if I do not return for my scheduled appointment for delivery of my crown, veneer, or denture, it may not fit properly, and I will be responsible for any lab fees incurred for a remake. I understand that following coronal procedures, teeth may become sensitive & require root canal. Problems of wearing dentures (looseness, soreness, breakage..) have been explained. Dentures require relining 6 months after placement, the cost of which is not included in the initial fee. (Initials —)
IMPLANTS: Implants are an alternative to bridges or dentures. It may be necessary for the extraction site to heal prior to implant work. Some conditions such as smoking, diabetes, osteoporosis, periodontal disease, cancer, etc... may prevent the implant from healing and attaching to the bone. These factors are beyond the control of the dentist, and agree not to hold him responsible should the implant fail. It may be necessary to perform other procedures (sinus lift, grafting) for the implant to succeed . Occasionally the implant may not be placed in exact alignment as the rest of the teeth and is possible to have swelling, pain, loss of feeling (paresthesia), and infection afterward. (Initials —)
ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal therapy will save my tooth, and complications (pain and infection) can occur. Occasionally filling material may extend through the root ,or it may not be possible to completely fill the root, which does not necessarily affect the success of the treatment. An additional surgical procedure (apicoectomy) may be necessary due to instrument breakage, inadequate seal, infection Treated teeth may turn grey ,and need crown immediately. Root canal may not relieve all the symptoms. (Initials—)
REMOVAL OF TEETH: Alternative to removal (root canal, crown, surgery) have been explained to me. I understand that this removal does not always remove all the infection, and I may need further treatment by a specialist or hospitalization if complications arise during or following treatment, the cost of which is my responsibility. The risks involved in removal of teeth such as pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue that can last indefinitely or permanently, fractured jaw, sinus opening, and damage to the adjacent teeth and bone have all been explained to me, and I authorize such removal by the dentist. (Initials —)
PERIODONTAL LOSS (TISSUE AND BONE): I understand that I have a serious condition causing bone/gum loss which could lead to the loss of all of my teeth. The alternatives such as surgery, extraction, etc. have been explained. I understand that this treatment may cause hot/cold sensitivity, and its results can not be guaranteed. (Initials —)
CROWN LENGTHENING: Gum tissue and bone covering the root will be removed to gain healthy tooth structure for the crown.. Teeth may become sensitive requiring root canal. Gum and bone may get inflamed , bleed, and hurt. It may also result in further recession, sinus/infraorbital ,or submandibular space exposure and swelling. (Initials —)
BLEACHING: May cause teeth/gum sensitivity, results vary per individual ;and are not guaranteed. (Initials —)
I authorize the dentist to perform dental work upon me to restore its health, function, and appearance. All the risks, benefits, alternatives, effects, complications (bleeding, infection, numbness, scaring, itching, fracture, sensitivity, etc) and consequences of treatment (or lack of) have been explained. Dentistry is not an exact science and even reputable practitioners can not guarantee results. No guarantee has been made by anyone regarding the treatment which I have requested and authorized. I certify that I fully understand the above and consent to the prescribed dental treatment.

Signature: ______________________ Date: ______________________

Doctor: ______________________ Witness: ______________________

Dental Financial Policy

Our practice is based on the simple truth that if we satisfy & delight our patients and they achieve the dental results they want, they are more likely to tell others about their dental experience.
Dentistry is not an exact science and therefore reputable practitioners cannot properly guarantee results.

As a courtesy to our patients we will call your Insurance Company to verify benefits.
Ultimately, the patient is responsible for the payment of all services provided by the office regardless of payment by your Insurance. We will not be liable for any misinformation given to us by your Insurance, and recommend that the patient personally contact their Insurance carrier if they should have any questions regarding their benefits prior to start treatment.

We will be happy to bill your Insurance for your care providing that you give us all the information we need to accurately verify your coverage. Even though you have Insurance coverage please remember that paying for your dental care is your personal responsibility. We expect payment from the Insurance within 30 days. We will automatically transfer and bill you for any payments not received from the Insurance after 45 days. You need to pay us in full at that time unless other arrangements are made with the office. Any amounts you personally owe and are 30 days late will receive a service charge of 1 ½% per month.

Occasionally the Insurance will send the payment to the patient. If this occurs, you are responsible to bring in the payment along with the explanation of benefits for such paid services to our office immediately.

If your Insurance request additional information from you to process the claims for services rendered in our office, its your responsibility to respond to them in a timely manner so they can process the claims for services rendered.

If you suspend, back date or terminate coverage with the Insurance Company while services are being provided, you are responsible to notify our office as soon as possible, and you will be responsible for any unpaid balances on your account.

You will need to pay your portion of the charges as you go. This includes the annual deductible, co-payment and charges your Insurance refuses to pay or that are not a covered benefit under your plan.

If you suspend or terminate your dental care against the advice of the doctor, all outstanding balances by you or due by your Insurance Company will become immediately due and payable by you personally before you leave the office.

*There is a charge of $50.00 for all broken appointments with out a 48 hour notice prior to your scheduled appointment.

*We don't accept checks over $100.00 and there is a NSF charge of $40.00 if your check is dishonored by your bank, the amount of the check plus the $40 must be paid in the form of cash or money order.

* Once treatment is diagnosed and started in our office, we reserve the right to finish the treatment.
You will be charged and will be responsible for the treatment regardless of whether you return to complete treatment or not. You must return within 2 weeks for delivery of a prosthetic appliance.
In case of undelivered dentures, crowns, bridges, veneers, orthodontic appliances, guards, and any other prosthetic devices that do not fit because you didn't come in on a timely manner for delivery, you will be responsible for the lab fee for the remake. No refunds will be given!

*All balances need to be paid in full before any case can be delivered to you.

* In case of unfinished root canals, fillings, implants, surgery.., you will be responsible for all the costs should it get re infected, and require re treatment and /or referral to a specialist.
*If you go to another dental office for treatment started in our office, or decide on your own to change treatment or provider, you may do that at your own expense.
* In the event that you have paid for your accepted treatment by Care-Credit or any other Credit Card and you then decide not to finish treatment and request a refund, you will be responsible to pay our office 14.9% of the total charge made on the Credit Card (this is the fee the Credit Card charges us).

My Signature below certifies that I have read and understand the terms and policies set by New Age Dental.

Patient Signature ______________________________ Date: ____________________

Our office policy does not allow us to extend credit in house. We do accept Care credit, Visa, Master Card, Discover and Debit payments.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name:____

Address:____

Telephone #: ______________________**E-Mail:**______________________________

Patient #:______________________**Social Security #:**__________________________

Section B: To the patient- **READ THE FOLLOWING STATEMENTS CAREFULLY!**
Purpose of Consent: By Signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of uses and disclosures we may make of your protected health information, and other important matters about your protected health. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any reservations of our Notice, at any time by contacting us.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation, of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE
I ______________________________have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____________________________ Date: __________________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________________

Relationship to patient:____