WELCOME!

1. PATIENT INFORMATION

Date:

Last Name _____ First Name _____ MI _____

Sex ☐ Male ☐ Female Soc. Sec. # _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State _____ Zip Code _____

Email _____ Cell Phone (_____)_____ Home Phone (_____)_____

Employer _____ Work Phone (_____)_____ Occupation _____

Emergency Contact _____ Relationship _____ Phone # (_____)_____

If under 18, Name of Parent _____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone (_____)_____

Reason for today's visit? _____

How did you hear about us? ☐ In-home Mailer ☐ Social Media ☐ Insurance ☐ Practice Website ☐ Google ☐ Other_____

☐ Family/Friend/Coworker: Who can we thank for your visit? _____

2. DENTAL INSURANCE INFORMATION *(Primary Carrier)*

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

3. DENTAL INSURANCE INFORMATION *(Secondary Carrier)*

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

4. FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards, or one of the third-party financing options we provide.

☐ **Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges.

Do You Have Insurance?

- *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, and your insurance company.*
- *As a courtesy to you we will help you process your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. 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 ask that you sign this form and/or any 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, check, credit card or one of the third-party financing options we provide.*
- *We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.*
- *I understand that my dental insurance coverage has certain restrictions and limitations, such as authorization requirements, waiting periods, as well as non covered services. Examples of these may include but are not limited to: Adult fluoride, bone graft, indirect pulp cap, nitrous oxide, Arestin, Porcelain crowns, resin fillings, clear aligners. Therefore any non covered service will not be sent to insurance. I understand I am financially responsible for any and all related charges if they are not covered by my dental insurance.*

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

For a detailed description of our privacy practices, please see our "Notice of Privacy Practices" folder at the front desk.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature/Legal Guardian *Date*

5. AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize the following person to have access to information covered under the Privacy Practice regarding myself.

Your Name

_____ _____

Name (Printed) Relationship

6. DENTAL HISTORY Please mark (x) on any of the following conditions that apply to you

Patient Name (print):

Appearance
- ☐ Discolored teeth
- ☐ Flat/worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Crowding
- ☐ Spaces/missing teeth
- ☐ Deep bite

Pain/Discomfort
- ☐ Sensitivity (hot, cold, sweets)
- ☐ Pressure/pain with chewing
- ☐ Broken teeth/fillings
- ☐ Dry mouth
- ☐ Other: _____

Function
- ☐ Grinding/clenching
- ☐ Morning headaches
- ☐ Jaw joint (TMJ) pain
- ☐ Jaw joint (TMJ) clicking/popping
- ☐ Speech impediment
- ☐ Mouth breathing
- ☐ Sore muscles (head, neck)
- ☐ Difficulty opening or closing
- ☐ Difficulty chewing on either side

Periodontal (Gum) Health
- ☐ Bleeding, swollen, irritated gums
- ☐ Bad breath
- ☐ Loose, tipped or shifting teeth
- ☐ Previous perio/gum disease

Habits
- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/lip biting
- ☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions
- ☐ Sleep apnea
- ☐ Snoring

Social

Tobacco packs per day _____
Alcohol frequency _____
Drugs frequency _____

Previous Comfort Options
- ☐ Nitrous oxide
- ☐ Oral sedation (pill)
- ☐ IV sedation

Frequent/Daily Use:
- ☐ Soda/sweet tea
- ☐ Coffee with creamer/sugar
- ☐ Sports/energy drinks
- ☐ Candy/sweets
- ☐ High carb diet

Please share the following dates: Your last dental visit _____ Your last cleaning _____

What is the most important thing to you about your dental visit today? _____

_____

On a scale of 1-10, with 10 being the highest rating: Dental Anxiety _____ Happy with your smile

What would you like to change about your smile? ☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth ☐ Teeth Sensitive to hot, cold, sweets or pressure ☐ Other

7. MEDICAL HISTORY Please mark (x) as your response to indicate if you have or have had any of the following

Medical Allergies
- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local anesthetics
- ☐ NSAIDs

Other allergies/comments

_____
_____
_____

Cancer

Type _____
- ☐ Chemotherapy
- ☐ Radiation therapy

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Heart conditions
- ☐ Heart surgery
- ☐ High/low blood pressure
- ☐ Pacemaker
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease

Gastrointestinal
- ☐ Reflux
- ☐ Gastrointestinal disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood disorders
- ☐ Bruise easily
- ☐ Excessive bleeding

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness/fainting
- ☐ Drug/alcohol addiction
- ☐ Seizures
- ☐ Psychiatric illness

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Respiratory problems
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV positive
- ☐ HPV
- ☐ Cold sores

Women
- ☐ Currently pregnant Due date: _____
- ☐ Nursing

Are you under the care of a physician? If yes, please explain _____

Physician Full Name _____ Phone (_____)_____

Have you had a serious illness, operation, or hospitalization in the past 5 years? If yes please explain _____

_____

Please check if you have any of these conditions: Artificial Heart Valve ☐ Previous Infective Endocarditis ☐ Damaged Heart Valves in Heart Transplant ☐ Unrepaired Cyanotic CHD ☐ Repaired CHD with Residual Defects ☐

Please list medications currently taking: _____

_____

Have you ever in the past, or are you now currently taking, any medications for Osteopenia/Osteoporosis or Bone Disease? If yes, please list medications:

_____

Are you on blood thinners? If yes, please list: _____

Consent:

I hereby authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the 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 have read, understand, and agree to the above terms and conditions.

_____ _____ _____

Signature of Patient/Legal Guardian *Print Name* *Date*

_____

Dentist/Hygienist Signature

Financial Policy

Thank you for choosing Dental Professionals Of Spring. Our primary mission is to provide the best and most comprehensive dental care available to all of our patients. Please review the following information carefully and let us know if you have any concerns regarding our financial policies.

Payment Options:

We accept the following payment options:

- Cash, checks or debit cards
- Visa, MasterCard, American Express, Discover
- Flexible payment Plans[2] from CareCredit
    - Short term plans that allow you to pay over time with NO INTEREST[1]
    - Extended, low monthly payment plans[2] also available
    - No annual fees or pre-payment penalties

Dental Insurance:

As a courtesy to you, we will gladly file claims for dental services to your dental insurance carrier; however, all co-payments and deductibles will be collected at the time of treatment. Insurance payments are **estimated** based on information obtained from your insurance company. Please be advised that while we spend a great deal of time and effort in obtaining insurance information as a service to our patients, we cannot guarantee payment from your insurance company nor predict allowable charges and payment amounts. **Therefore, you will be responsible for any outstanding balances that are not covered by your dental insurance within a reasonable time frame, regardless of cause.**

I understand that my dental insurance coverage has certain restrictions and limitations, such as authorization requirements, waiting periods, as well as non covered services. Examples of these may include but are not limited to: Adult fluoride, bone graft, indirect pulp cap, nitrous oxide, Arestin, Porcelain crowns, resin fillings, clear aligners. Therefore any non covered service will not be sent to insurance. I understand I am financially responsible for any and all related charges if they are not covered by my dental insurance.

By signing below you agree to the release of all necessary information to your insurance company for the processing of claims and you authorize payment from your insurance company directly to our office. Any changes to this authorization must be received in writing within 30 days of the effective date.

Please also note:

- There is a $50 fee for rescheduling or canceling appointments with less than 48 hours notice.
- There is a $35 fee for returned checks
- There is a 3% surcharge applied on all credit card transactions which is no greater than our cost on accepting credit cards. There is no surcharge applied on debit cards or cash transactions

If you have any questions or concerns, please do not hesitate to ask. We are here to help.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date.

Minimum monthly payment required.

[2]Subject to credit approval

DENTAL PROFESSIONALS Spring

Acknowledgement of Receipt of Notice of Privacy Practices

You may Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notices of Private Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

_____

_____

_____

Patient Communication

We provide our patients the option to participate in our online **Patient Communication System**. Some of the features include the ability to:

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

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

Name:_____

___Check here to Opt In to Text Messages ___Check here to Opt Out

___Check here to Opt In to Email ___Check here to Opt Out

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Dental Professionals of Spring: Dr. Ahsan Raina 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 Dental Professionals of Spring: Dr. Ahsan Raina in the administration of your benefits. Our affiliates do not sell, share or rent our user's 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 that you agree to allow us to use this information in providing your services.

_____

Signature Date

Dental Insurance and Health Care

We frequently get questions from patients regarding their dental insurance benefits. In order to assist our patients in understanding how dental insurance works, we have developed the following information sheet. We hope it will be helpful, and we are always here to help answer any additional questions that you may have.

Your dental insurance is typically selected for you by your Human Resources department. It is typically a part of the benefits package your employer offers you. Our office does not take any part in that process. In addition, we are never involved in how insurance companies set their rates or make their decision.

Your dental insurance company operates completely independently of us. Our office and the insurance company are not in partnership in any way.

Moreover, as the provider of your oral health care, our office and your insurance company operate under a completely different set of objectives.

Insurance Provider Objectives:

Insurance companies make their decisions based solely on business revenues. They have shareholders and a board of directors who expect them to make consistent profits. This is the main focus for insurance companies; this is why they are in the insurance business.

Your Dentist's Objectives:

Dr. Raina makes his decision based solely on what is best for your oral health. He utilizes his knowledge of science and clinical research, accepted standards of clinical care, his years of experience and his deep dedication to your overall health every time he recommends services or treatment.

With these two different approaches, what is on an insurance company's list of 'covered' services will not always match the list of services recommended for you. However, the services we recommend are focused on maintaining health. As such, we do not send non-covered services to insurance.

With all this said, we know that having dental insurance is a terrific benefit and it does contribute toward some of your dental services; it just will not cover every needed service. Please remember that your insurance portion is an 'estimated' portion. It is not a guarantee that the insurance will pay the whole billed amount. Our office is happy to help you work with your insurance to optimize the benefits your employer has offered you. If you have any questions regarding your insurance coverage, we will be happy to answer them to the extent possible. You can also contact your insurance provider directly to get a better understanding of what services are covered specifically under your policy.

Finally, if you are unsatisfied with the coverage provided to you by your insurance, you may contact your employer's Human Resources department and request changes to your benefits.