true dentistry

Welcome to our practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

E-mail Address: _____, Last Name: _____ First Name: _____

Preferred to be called: _____, Street Address: _____

City, State, Zip: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

SS#: _____, Driver's License: _____ Sex: ☐M ☐F Occupation: _____

Employer: _____, Address, City State, Zip _____

Emergency Contact Name: _____ Phone # : _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____, City, State, Zip: _____

Spouse's Employer: _____ Address, City, State, Zip: _____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: _____, Place_____ Time: _____

How did you hear about our office? Please check: _____Internet ☐Patient referral ☐Website ☐Yellow Pages ☐Mailer Other _____

If you were a referral, whom may we thank for their trust in us? _____

INSURANCE INFORMATION:

Primary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____:Member's ID# _____ Birth date: _____

Group# or Policy # _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to True Dentistry of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: _____ Patient's Signature: _____

CONSENT:

I hereby authorize True Dentistry to take the necessary x-rays, study models, photographs or any other diagnostic aids deemed appropriate by True Dentistry to make a thorough diagnosis of the patient's dental needs, lab needs; and for the use of dental education, which may include full face or smile photos. I waive any claim which might accrue to me personally on account of the use of such photographs, x-rays. I also authorize True Dentistry to perform 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 my dental insurance is a contract between me and the insurance carrier and not between True Dentistry and your insurance company. I fully understand that it is my financial responsibility only for all dental treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____ Dr. Signature: _____

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HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

_____ (Date}_____
(Signature of Patient and/or Guardian)

(Relationship to Patient) Self or Other: _____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement at time of service
- ☐ Other (Please specify) _____

Our Financial Philosophy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone. So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits.

Regarding Insurance:
We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 **days.**

WE ACCEPT CASH, CHECKS OR DISCOVER, MASTERCARD, VISA, AMERICAN EXPRESS WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which I give my consent for a credit check.

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If True Dentistry must take additional steps to collect my account, I will pay ALL cost of collection fees of 40% and including any court cost and attorney's fees incurred by Dr. Willardsen and True Dentistry. I give consent for any credit check to be completed by True Dentistry should it be deemed necessary.**

Cancellation Fee: True Dentistry has a 48 hour cancellation policy. Any no show appointments or appointments cancelled less than 48 hours are subject to a $50/per hour cancellation fee of the appointment time scheduled.

I have read the Financial Philosophy. I understand, accept, and agree to this Financial Philosophy.

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Witness for True Dentistry Date

MEDICAL HEALTH HISTORY **PATIENT NAME: _____ Date: _____**

A. CHECK ALL THAT APPLY (leave BLANK if you do not understand the question):

1. ☐ Are you in good health?
2. ☐ Has there been a change in your health within the last year? Explain: _____
3. ☐ Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____

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4. Are you being treated by a physician now? For what? _____

Name of your physician: _____ Date of last Medical Exam: _____

B. HAVE YOU EVER EXPERIENCED?

5. ☐ Chest Pains
6. ☐ Swollen Ankles
7. ☐ Shortness of breath
8. ☐ Recent weight loss, fever, night sweats
9. ☐ Persistent cough, coughing up blood
10. ☐ Bleeding problems, bruising easily
11. ☐ Sinus Problems
12. ☐ Difficulty swallowing
13. ☐ Joint pain, stiffness
14. ☐ Jaundice
15. ☐ Dizziness
16. ☐ Ringing in ears
17. ☐ Frequent Headaches
18. ☐ Fainting spells
19. ☐ Blurred Vision
20. ☐ Seizures
21. ☐ Excessive thirst
22. ☐ Frequent urination
23. ☐ Dry Mouth
24. ☐ Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

25. ☐ Heart disease/ Heart murmur
26. ☐ Heart attack, heart defects,
27. ☐ Asthma
28. ☐ Rheumatic fever
29. ☐ Stroke, hardening of arteries
30. ☐ High Blood Pressure
31. ☐ TB, emphysema or other lung diseases
32. ☐ Hepatitis, ☐ A ☐ B ☐ C
33. ☐ Stomach problems, ulcers
34. ☐ Diabetes
35. ☐ Mitral Valve Prolapse
36. ☐ HIV positive or AIDS-ARC
37. ☐ Tumors, Cancer
38. ☐ Arthritis, rheumatism
39. ☐ Eye disease
40. ☐ Skin disease
41. ☐ Anemia
42. ☐ VD (syphilis or gonorrhea)
43. ☐ Herpes
44. ☐ Kidney, bladder diseases
45. ☐ Thyroid, adrenal diseases
46. ☐ History of diabetes, heart problems, cancer

D. DO YOU HAVE OR HAVE YOU HAD:

47. ☐ Surgeries _____
48. ☐ Blood Transfusions _____
49. ☐ Artificial Joint _____
50. ☐ Contact Lenses _____
51. ☐ Psychiatric Care _____
52. ☐ Radiation Treatments
53. ☐ Chemotherapy
54. ☐ Prosthetic heart valve
55. ☐ Pacemaker
56. ☐ Currently taking Birth Control Pills
57. ☐ Currently Pregnant or nursing

E. DO YOU TAKE OR HAVE TAKEN:

58. ☐ Recreational drugs
59. ☐ Alcohol
60. ☐ Tobacco in any forms
61. ☐ Phen Phen diet Pills or any other diet pills
62. ☐ Fosamax/Boniva or other Bisphosphonate drugs

F. VITAMINS & MEDICATIONS: _____

_____

_____

ALLERGIES: **LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:**

_____

G. ALL PATIENTS:

63. Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

64. Have you ever been told by a physician or dentist that you need to pre-medicated with antibiotics prior to any dental treatment for artificial joints or heart conditions?

DENTAL HEALTH HISTORY PATIENT NAME: _____ Date: _____

H. Name of your former Dentist: _____ How long since you were last seen? _____

65. Is keeping your teeth important to you? If yes, why? _____
66. On a scale of 1-10, 10 being the best, where would you rate your smile? ☐
67. On a scale of 1-10, 10 being the best, where you rate your oral health? ☐
68. Have you experienced any of the following problems:

☐ Bleeding gums	☐ Sensitivity to Hot & Cold
☐ Bad Breath or sour taste in mouth	☐ Snoring
☐ Burning sensations in mouth	☐ Food catching between teeth
☐ Soreness in jaw	☐ Clenching or Grinding of Teeth
☐ Is it hard for you to open wide?	☐ Pain/soreness around ears, eyes, face
☐ Clicking or popping in jaw	☐ Stiff neck muscles
☐ Do you or your parents wear dentures/partials?	☐ Do you smoke or chew tobacco?

70. Does having dental treatment make you afraid or nervous? If yes, what specific things bother you? _____

_____

71. Is the brightness of your teeth important to you?

72. If you could change anything about your smile which of the following would you want?

☐ Whiter	☐ Close space or spaces	☐ Replace chipped teeth
☐ Replace missing teeth	☐ Replace old crowns	☐ Remove silver fillings
☐ Remove Stains/Spots on teeth	☐ Excess showing of Teeth	☐ Replace old plastic filling(s)
☐ Straighter	☐ Less Gum showing	☐ Reshape/resize my teeth

73. Fill in this question for us please: Together, what goals would you like for your oral health lifetime care ?

74. In presenting your treatment plan and talking to the doctor please let us know which is best for you?:
_____ I like lots of information and details _____ I like just the basics and facts

75. **Please let us know which is most important to you when making your dental health decision. Number from 1 to 5 in order of importance.** *******1 being most important and 5 being least important *******

_____ Quality of Care
_____ Comfort of Care
_____ Finances and budget
_____ Time
_____ Relationship with Doctor and Staff

Patient Signature: _____Date: _____