

# New Patient Forms

## Patient Information: (All Fields Required)

Date: \_\_\_\_\_

Legal First Name: \_\_\_\_\_ Last: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Apt?  No  Yes: Apt #: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Cell: \_\_\_\_\_ Prefer Contact By:  Call  Text  Email

**Check one:**  Male  Female |  Single  Married  Separated  Divorced  Widowed

**How did you hear about us?**  Internet/Google  Insurance  Drive-By  Family/Friend: \_\_\_\_\_

**Patient is:**  Responsible Party  Policy Holder

## Responsible Party: (Fill ONLY if you are the spouse, parent, or guardian)

Legal First Name: \_\_\_\_\_ Last: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Apt?  No  Yes: Apt #: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Cell: \_\_\_\_\_ Prefer Contact By:  Call  Text  Email

## Insurance Information:

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Ph #: \_\_\_\_\_

## Welcome to our Dental Family! We just wanted to brief you on a few benefits to our practice!

1. Don't have dental insurance? No Worries! Ask about our DENTAL SAVINGS PLAN saving you up to 50% off. We can get you **financed** for work you need at a monthly payment that is right for you! **Low monthly payments** to help you and your family and friends get the dental work they need.
2. Nervous about Dental Work? We offer sedation while you sleep through your dental visits.
3. Want Whiter Teeth? We can whiten your teeth 3-5 shades in 20 minutes with no sensitivity!
4. Busy Schedule? We offer appointments as early as 7am and as late as 7pm Monday to Friday, AND Weekends.
5. Our doctors are highly trained and we are here to handle all of your dental needs under one roof!

**Thank you for choosing us as your dental home!**

# New Patient Forms

**Medical History** | Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications do affect our ability to perform treatment.

**(For all Yes's, you must provide details)**

Are you under a physician's care now?	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	
Have you ever had a serious head or neck injury?	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	
Are you taking any medications, pills, or drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	
Do you take, or have taken, Phen-Fen or Redux?	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	
Are you on a special diet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	
Do you use tobacco?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: How many per day?	__ Singles __ Packs

Women Only:

- Pregnant    Trying to get pregnant    Nursing    Taking oral contraceptives    None of the above

Allergies:

- Aspirin    Penicillin    Codeine    Acrylic    Metal    Latex    Sulfa Drugs    Local Anesthetics  
 None known drug allergies

Are you allergic to anything not listed above?	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	
Do you use controlled Substances?	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	
Others?	<input type="checkbox"/>	:	

Mark everything you have or have had only:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> Alzheimer's Disease       | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Artificial Joint          | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Breathing Problems        | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Genital Herpes            | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pacemaker           | <input type="checkbox"/> Psychiatric Care      |   |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Heart Trouble/Disease     | <input type="checkbox"/> Radiation Treatments  |   |
| <input type="checkbox"/> Yellow Jaundice           | <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Recent Weight Loss    |   |

Have you ever had any serious illness not listed above?    No    Yes: \_\_\_\_\_

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# New Patient Forms

## Office Financial Policies

*Helping You Save Money on Quality Care*

Thank you for choosing our office for your dental needs. Our primary mission is to deliver the best service and most comprehensive dental care available. We are focused on your complete oral health and everything we do is centered on this philosophy. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible.

**Your Insurance:** We must emphasize that as a dental care provider, our relationship is with YOU and NOT your insurance company. Our office policy is to provide the highest quality dentistry for each our patients, regardless of insurance limitations. We are an In-Network Provider for most insurance, which means that we have contracted with your insurance company so that you will receive the highest quality care at the lowest possible fees and receive the maximum amount of insurance coverage.

Please be aware that some services may not be covered under the provisions of your insurance plan. You will be responsible for any difference. We require that all deductible, co-pays, and/or any percentage of the bill that your insurance does not cover to be paid at the time of service. If, after 45 days of nonpayment from the insurance company, the balance is the patient's responsibility and payment is due within 30 days.

**Payment Options:** The office requires payment on the date of your treatment unless other written financial arrangements have been made. We accept Cash, Check, Visa, MasterCard, American Express, Discover and CareCredit.

**Late & Missed Appointment:** We pride ourselves on seeing all our patients On-Time, and in order to help us stay On-Time, we follow a strict 10-minute late appointment policy. If you arrive late for your appointment, we reserve the right to reschedule the appointment. A fee of \$50 is charged for patients who miss or cancel more than once in a calendar year without prior 48-hour notification. For any surgery time scheduled, cancellation fee can range from \$50-\$200 in last minute cancellation fees. This also includes the deposit paid to schedule surgery.

**Returned Check:** Our office charges \$45 for returned checks.

**Default on Payment:** If your account is turned over to our collection agency, you will be responsible to pay a service fee of \$125, any collection agency fees, court and attorney fees in addition to the balance owed.

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Patient Name (Please Print)

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Parent/Guardian if applicable (Please Print)

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Patient, Parent or Guardian Signature

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Date

# New Patient Forms

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

# New Patient Forms

## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$50 for each set of x-rays and \$20 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format(via email), we will charge a cost-based fee of \$25 for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.) **Note: This is dictated by the US Government and is part of the Privacy Act.**

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officers: Aniket Solanki | Joann Nguyen

Phone: 972-675-7695 | 972-675-7695

E-mail: Aniket@NexDent.net | Joann@NexDent.net

Patient(s) \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent/Guardian if patient is a minor)

# New Patient Forms

## Dental Information/History

What is the reason for your visit today? \_\_\_\_\_

Approximate date of your last dental cleaning (Month/Year): \_\_\_\_\_

Have you ever had any complications or problems with dental treatment? **YES NO**

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Rate your dental health: 1(Worst) - 5(Best) 1 2 3 4 5

Rate your smile: 1(Worst) - 5(Best) 1 2 3 4 5

Do you consider yourself a PROACTIVE person? Someone who likes to avoid complications. Take care of an issue today instead of letting it worsen or hurt over time.

**YES NO**

Do you consider yourself a REACTIVE person? Someone who would rather wait and deal with any issues as they develop.

**YES NO**

**What do you value most in a dental office?** Looks, Function, Comfort, or Longevity?

\_\_\_ **COSMETIC** - How your teeth look – You want your smile to be straight and white

\_\_\_ **FUNCTION** - The ability to enjoy your favorite foods and drinks and eat and drink what you like.

\_\_\_ **COMFORT** - NOT being in pain from sensitive teeth and gums.

\_\_\_ **LONGEVITY** - The ability to have keep natural teeth or have the highest quality, longest lasting work.

**What obstacles have prevented you from consistent dental care?** Fear, Time, Money, Trust, or No Urgency?

\_\_\_ **NO OBSTACLES** - I come faithfully every 6 months and value my dental health.

\_\_\_ **FEAR** - Of pain. Noises. Environment. Past experiences.

\_\_\_ **TIME** - Busy schedule. Not able to take off work or school.

\_\_\_ **NO URGENCY** - Nothing really hurts so there has not been a need to see a dentist.

\_\_\_ **MONEY** – Have not been able to budget for dental care.

\_\_\_ **TRUST** - Felt you were told you needed treatment you didn't need. Felt ripped off. Didn't give me any data to support treatment they recommended.