

WELCOME TO OUR DENTAL PRACTICE!

Let me take this time to welcome you to our practice on behalf of myself and my staff. We appreciate that you have selected our dental team to provide you with excellent dental health. We take pride in and are committed to providing you quality oral health in a comfortable, gentle, and professional environment.

During your initial visit, a thorough examination will be performed. It will include the appropriate digital x-rays, complete oral exam, and an oral cancer screening.

We strive to maintain and retain the health of your natural teeth. By working together to develop a mutual understanding and clarify our expectations of one another, we will reach that goal. I strongly encourage you to inquire at any time about any aspect of your treatment plan.

Enclosed you will find our patient health questionnaire. Please complete this form and bring it to your first visit. If you have dental insurance, please bring your benefit information.

Best Regards,

James P. Toner D.D.S.

OFFICE POLICIES AND FINANCIAL AGREEMENT

It is our desire to make high quality dental care affordable to everyone. The following is a statement of our office policy and financial policy, which we ask that you read, agree to, and sign before any treatment is rendered.

Most dental insurances have limits and/or various degrees of co-payments. The treatment recommended by my office is never based on what your insurance will pay; your treatment **should not** be governed by your insurance contract.

My office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment the patient/guarantor is responsible for the portion the insurance does not cover. Please be aware that some insurance companies may not cover all services performed in my office. The patient/guarantor is responsible for all charges that are denied or unpaid by your insurance carrier. If for some unforeseen reason your insurance carrier has not made a payment within 90 days, the patient/guarantor is responsible for these charges.

Minors

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, treatment will be denied, unless treatment and the charges have been pre-authorized by the parent or legal guardian.

*****CANCELLATION POLICY*****

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two (2) business days notice. Please call during business hours rather than leaving a voicemail after hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. Patients will be subject to a \$50.00 late cancellation fee.

Initial _____

*****FAILED APPOINTMENT POLICY*****

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, patients will be subject to a \$50.00 charge for a missed appointment. "NO SHOW"

Initial _____

Regarding Insurance

If the patient has any insurance charges or maxes out of benefits, it is the patients/guarantor's responsibility to be aware of it and provide the information. If this information is not provided at the time of service the patient/guarantor will be responsible for the charges incurred.

I understand my dental insurance is a contract between the insurance carrier and the patient, not between doctors and insurance carrier. Please note that NO individual in the office can predict exactly what amount your insurance will pay. When we verify your coverage with your insurance company, they also indicate that there is no guarantee of coverage, until they receive the claim. We will only be able to give you an estimate and we cannot be held responsible to that estimate any way. In some cases, insurance companies use alterative benefits as a method of payment and not pay the total estimated amount. Therefore, do not hold us responsible for payments that a third party may refuse to pay.

Initial _____

OFFICE POLICIES AND FINANCIAL AGREEMENT

Past-Due Accounts

I understand that I am financially responsible for all charges incurred in full by myself and/or my dependents. I agree that in the event my account is past due in excess of ninety (90) days from the date of service, it may be turned over to a collection agency unless arrangements are made in advance. Monthly interest rate of 1.5% (18% APR) may be incurred for accounts ninety (90) days past-due. I agree that I am liable for all collection charges including but not limited to attorney and legal fees in the event my account was turned over to collection agency.

A fee of \$30.00 will be charged on all returned checks.

Managed Care Plans

I do not participate in any managed care, HMO, or DMO plans.

Insurance Signature Authorization

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me and my dependent and/or other health practitioners relating to all claims for benefits submitted on behalf of myself and/or dependents. I agree and acknowledge that my signature on the document authorizes my dentist to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim submitted for myself and/or my dependents. I will be bound by this signature as though I had personally signed each claim. I hereby assign all medical, dental, and/or surgical benefits to which I am entitled for this service to Dr James Toner. A photocopy of this assignment is to be considered as valid as an original.

Authority To Treat

I give Dr. James Toner the authority to administer dental x-rays, local injections, anesthetics, and if requested, a tranquilizer in the subsequent treatment of my case. If I have a medical condition, that requires premedication, or any drug allergy, I acknowledge that it is my responsibility to inform and remind the Doctor, Assistant, or the Hygienist every time before treatment. Please advise my office of ANY and ALL medications you may be taking – especially any blood thinners (Aspirin on a daily basis or Coumadin).

I have read, understand, and agree to the above Office Policies and Financial Agreement.

Patient Name

Patient Signature (parent or legal guardian if patient is a minor)

Date

Email Address:

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

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ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First MI Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ___ SS#: _____

Home Address: _____
Apt./Condo #

_____ City State Zip

Single Married Partnered Divorced/Separated Widowed

Hm #: (____) _____ Cell #: _____

Wk #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

_____ City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

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SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Contact #: (____) _____ Ext: _____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Relative or Friend not living with you (for emergency).

His / Her Name: _____ Relation: _____

Contact #: (____) _____

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INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____ City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____ City State Zip

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____ City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____ City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

CONTINUED ON BACK

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MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one: _____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) Yes No

If so, when? _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N HIV + |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

Please list any other drugs/materials that you are allergic to: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

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DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Your current dental health is: Good Fair Poor

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft

Have you ever had gum treatment? Yes No

Do your gums ever bleed? Yes No Ever Itch? Yes No

Have you ever had periodontal disease? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? Yes No

Do you still have wisdom teeth? Yes No

Would you like fresher breath? Yes No Whiter teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____

Date _____

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____