

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City/State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Reason for today's visit:** \_\_\_\_\_  
**Email:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Check if you have or have had problems with any of the following:**

- Bleeding gums
- Periodontal treatment
- Clicking or popping jaw
- Sensitivity to sweets
- Loose teeth or broken fillings
- Food collection between teeth
- Mouth odors/bad taste
- Grinding teeth
- Orthodontic treatment
- Sensitivity when biting
- Fear of dental treatment
- Sensitivity to hot or cold
- Oral surgery
- Cold sores or other lesions
- Restless sleep/snoring

**Are you satisfied with the appearance of your teeth?** \_\_\_ Yes \_\_\_ No  
**Would you like a whiter smile?** \_\_\_ Yes \_\_\_ No      **Would you like straighter teeth?** \_\_\_ Yes \_\_\_ No

**Medical History**

**Are you currently under physician care?** \_\_\_ Yes \_\_\_ No      If yes, explain: \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Have you had any serious illness or operations?** \_\_\_ Yes \_\_\_ No      If yes, explain: \_\_\_\_\_

**WOMEN:** Pregnant? \_\_\_ Yes \_\_\_ No      If yes, how many months? \_\_\_\_\_      Nursing? \_\_\_ Yes \_\_\_ No

**Check if you have or had any of the following:**

- Anemia
- Arthritis/Rheumatism
- Circulatory Problems
- Epilepsy/Seizures
- Asthma
- Back Problems
- Diabetes
- Heart Problems
- Herpes
- Chemotherapy
- Heart Murmur
- Venereal disease
- Hepatitis
- Cough up Blood
- Tobacco habit
- Persistent Cough
- HIV/AIDS
- Headaches/Migraines
- Chemical dependency
- Pacemaker/Heart Surgery
- Skin Rash
- Liver Disease
- Kidney Disease
- Rapid weight loss/gain
- Respiratory Disease
- Stroke
- Psychiatric Care
- Shortness of breath
- Sinus Problems
- Jaw Pain
- Fainting/Dizziness
- Thyroid Problems
- Cholesterol
- Tonsillitis
- Radiation Treatment
- Blood Pressure low/high
- Autoimmune Disorder
- Ulcer
- Rheumatic/Scarlet Fever
- Artificial Joints
- Other, explain: \_\_\_\_\_
- Tuberculosis
- Swelling of feet/ankles
- Cancer/Tumors
- Cortisone Treatments
- Hemophilia/Abnormal bleeding
- Artificial heart valves
- Blood Transfusion

**PLEASE LIST ALL ALLERGIES- INCLUDING ALLERGIES TO ANY MEDICATIONS OR SUBSTANCES:**








**INSURANCE AND OFFICE  
POLICIES**

**To All Patients:**

It is customary to pay for services at the time services are rendered. If you are covered by an insurance plan we will be happy to file the claims for you; however, the responsibility for payment will remain with you. On each visit you will be required to pay your portion at the start of your visit.

We accept cash, check, Visa, MasterCard, Discover, American Express, and third party financing.

**Dental Insurance is a contract between the insured (you) and the insurance company. We are not involved.**

Your insurance company may or may not pay more or less on your dental claim.

In order to get credit from your insurance, you must supply us with the complete information about your coverage including any necessary forms, subscriber number, and date of birth, social security numbers, and group numbers.

**Appointment Policy:**

Dentistry by Design and Aesthetics by Design reserves appointments for each individual at a specific time to provide the best attention and care for you. We do our best to respect your time and ask that you reciprocate in return. Appointments that are moved, cancelled, or failed with less than a 48-hours advanced notice will be charged \$100 per hour. This fee must be paid prior to scheduling a next appointment.

**Financial Considerations:**

You will be quoted a fee prior to treatment. Payment is always expected when services are rendered. For treatment totals \$5000.00 or more will require a deposit to schedule. If the surgery visit is canceled or rescheduled outside of the appointment policy hours, the deposit will not be returned.

**Late and Finance Charges:**

A \$25.00 late payment charge may be applied to accounts that are late. A 1.5% finance charge will be added per month to all overdue accounts. If your account falls into delinquency, you agree to pay any and all collection agency fees, attorney fees, and court fees.

**By signing this statement you are agreeing to all terms listed above.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient/Responsible Party (if patient is a minor)**



**HIPAA AND PRIVACY POLICIES**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our full notice before signing consent. The terms of our Notice may change.

If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that:**

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore payment in full is required at the time services are rendered.

**Information Sharing:** Please list any individuals we can share your personal information with other than healthcare providers.

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

\_\_\_\_\_  
 This HIPAA Consent/Sharing was signed by (Signature) Date  
 \_\_\_\_\_  
 Relationship to patient (if other than patient)

# Patient Screening Form

Patient Name:

	IN-OFFICE
	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.**

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.

**X**