DAYSPRING DENTAL

DATE: _____

ADULT|PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____

D.O.B: _____ Gender: _____ Social Security #: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

Cell Phone #: _____ Home Phone #: _____

Email: _____

Spouse|Partner's Name (if applicable): _____

PREFERRED METHOD OF CONTACT (Please circle all that apply below)

Home Phone Cell Phone Text Email

Employer: _____ Years Held: _____

Present Work Position: _____ Work Phone #: _____

Business Address: _____ City: _____

State: _____ Zip Code: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Cell Phone #: _____ Home Phone #: _____

Work Phone #: _____

DAYSPRING DENTAL

INSURANCE INFORMATION

Primary Company: _____ Policy/Group #: _____

Policy Holder: _____ D.O.B: _____

Policy Holder SS/ID #: _____

Address Of Company: _____ Phone #: _____

_____

Secondary Company: _____ Policy/Group #: _____

Policy Holder: _____ D.O.B: _____

Policy Holder SS/ID #: _____

Address Of Company: _____ Phone #: _____

_____

Who will pay this account? _____

HOW DID YOU HEAR ABOUT US? (Please circle all that apply below)

Website Drive By Facebook Health Provider Friend Other

- Please specify: _____

DAYSPRING DENTAL

ADULT|PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____

D.O.B: _____ Current Age: _____ Gender: _____

HEALTH PROVIDER

Primary Care Physician: _____ Phone #: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Preferred Pharmacy: _____ Phone #: _____

May we request your records? Y N

Are you receiving any other health care? Y N

MEDICAL HISTORY|INFORMATION

Date of last medical exam: _____ Purpose of exam: _____

Have you been hospitalized in the last five years? Y N

- If yes, please explain: _____

Any allergies/adverse reactions to medication(s)? Y N

- If yes, to which medication(s)? _____

Are you presently taking any medication(s)? Y N

- If yes, please list medication, dose and reason: _____

_____

_____

Do you use tobacco? Y N

- If yes, for how long? _____ How much? _____

_____ _____

Patient Signature Date

DAYSPRING DENTAL

MEDICAL HISTORY|INFORMATION (CONT)

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Acid Reflux	Y	N	High Blood Pressure	Y	N
AIDS	Y	N	Hip/Joint Replacement	Y	N
Allergies	Y	N	HPV	Y	N
Alzheimer's	Y	N	Insulin Pump	Y	N
Anemia	Y	N	Kidney Disease/Stones	Y	N
Angina	Y	N	Latex Allergy	Y	N
Arthritis	Y	N	Liver Disease	Y	N
Asthma	Y	N	Low Blood Pressure	Y	N
Blood/Bleeding Disorder	Y	N	Lung Disease	Y	N
Bone Disorder	Y	N	Mental/Emotional Problems	Y	N
Brain Injury	Y	N	Neurological Disorder	Y	N
Cancer	Y	N	Osteoporosis	Y	N
CPAP	Y	N	Pacemaker	Y	N
Diabetes (Type 1 | Type 2)	Y	N	Problems Swallowing	Y	N
Defibrillator	Y	N	Prosthetic Joint(s)	Y	N
Dementia	Y	N	Psychiatric Treatment	Y	N
Endocarditis	Y	N	Radiation Treatment	Y	N
Epilepsy	Y	N	Rheumatism/Rheumatic Fever	Y	N
Headaches/Migraines	Y	N	Seizures	Y	N
Hearing Impaired	Y	N	Sinus Problems	Y	N
Heart Attack	Y	N	Sleep Apnea	Y	N
Heart Disease	Y	N	STD	Y	N
Heart Valve Replacement	Y	N	Stroke/TIA	Y	N
Hepatitis/Jaundice	Y	N	Substance Abuse	Y	N
			Thyroid Disease	Y	N
			Tuberculosis	Y	N

Other physical conditions we should be aware of: _____

_____

DAYSPRING DENTAL

DENTAL HISTORY|INFORMATION

What is the reason you're at the dentist today? _____

How long has it been since you've seen a dentist? _____

When was your last dental exam? _____

last dental cleaning? _____

last full series of x-rays? _____

What did you like most about your previous dentist? _____

What did you like least about your previous dentist? _____

Do you believe your oral health is poor?	Y	N	
Are you apprehensive about dental treatment?	Y	N	
Have you ever worn braces?	Y	N	
Have you had any periodontal(gum) disease?	Y	N	
Do your gums bleed, feel tender or irritated?	Y	N	
Are your teeth sensitive to hot or cold?	Y	N	
Sensitive to sweets or pressure?	Y	N	
Do you avoid chewing on one side of your mouth?	Y	N	If yes, why? _____
Do you wear dentures? (Partial or Full)	Y	N	
- If yes, are you unhappy with your dentures?	Y	N	
Care to know more regarding permanent replacements?		Y	N
Are you unhappy with your appearance?		Y	N

If so, what would you change? _____

Are you unhappy with the way your teeth look?	Y	N
Would you like to improve the look of your smile?	Y	N
Would you like information regarding our whitening options?	Y	N

How often do you brush? _____

floss? _____

Please RANK the following in the order in which they would KEEP YOU FROM having/putting off dental treatment: LACK of concern _____MISSING time from work _____

FEAR of pain _____ COST of treatment _____

_____ _____

Patient Signature Date

DAYSPRING DENTAL

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment of services is due at the time services are rendered. If you have dental insurance, you must make the estimated co-payments at the time of treatment, and you are completely responsible for anything the insurance company does not want to pay within 45 days after billing. We accept cash, personal checks, Visa, Mastercard, Discover and American Express. We also offer Care Credit, interest free financing for your choice of 3, 6, 12, or 18 months upon qualifying. Please ask for an application if you are interested. Returned checks or balances older than 30 days may be subject to additional collection fees. Charges may also be made for missed appointments and appointments canceled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a Party to that contract.

2. Not all services are a covered benefit in all contracts. Some insurance companies select services they will not cover. You become financially responsible for these services.

3. Please be advised that this office does not place silver fillings in posterior (back) teeth. We only place white composite filling material, 99% of all insurance companies only allow for amalgam (silver) filling material, but will pay an alternate benefit for the silver. This means you, the patient then becomes responsible for any difference.

4. In cases of divorce or separation with children involved it is our office policy that the parent who has residential custody is responsible for paying any co-payment and/or deductible at the time of service. If insurance is involved and they pay less than expected, again the parent with residential custody is responsible for the balance. We will give the parent receipts to obtain reimbursement from other parties involved.

DAYSPRING DENTAL

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE (CONT)

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy we extend to our patients; all charges are your responsibility from the date services are rendered. If financial problems do arise we encourage you to contact our office promptly so that we may help you with the management of your account.

Again, thank you for selecting Dayspring Dental for your dental needs. If at any time you have a question regarding your treatment, fees or services, please contact us promptly to discuss.

By signing this paper you agree to and fully understand our payment policy.

_____ _____

Signature Date

If you have dental insurance please sign and date below as "Signature on File" so that we may manually or electronically submit your dental claims on your behalf.

_____ _____

Signature Date

DAYSPRING DENTAL

PAYMENT OPTIONS

We feel that it is very important for us to provide you with the treatment that is wanted and needed, therefore, we have several payment options available for your convenience. Please indicate which option(s) will work best for you.

INSURANCE:

- ▢ I do not have insurance to cover your fees.
- ▢ I have insurance coverage and would like you to file my claim and charge me for my estimated portion at the time of service.
- ▢ I have insurance coverage and will pay you directly then file my own claims for reimbursement.

OTHER PAYMENT:

I recognize that I am responsible for all fees related to my treatment. For that portion not covered by my insurance I will pay by:

- ▢ Cash or Check
- ▢ Visa, MasterCard, American Express, Discover or Debit Card
- ▢ Care Credit
    - ▢ I have one, my account # is _____
    - ▢ I wish to apply

_____ _____ _____

Patient's Name (Please Print) Signature Date

DAYSPRING DENTAL

MAY WE SHARE YOUR PHOTOS?

- ☐ Facial Photo
- ☐ Mouth and/or Teeth
- ☐ Use of both listed above
- ☐ Educational purposes only
- ☐ On Our Website
- ☐ On Dayspring Dental's Facebook/Instagram

_____	_____	_____
Patient's Name (Please Print)	Signature	Date

DAYSPRING DENTAL

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Privacy Officer,

DATE: _____

PATIENT NAME: _____

D.O.B: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides, in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

Understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of PRivacy Practices on request.

_____ _____

Signature Date

_____

Relationship to Patient
(if signed by a personal representative of patient)

DAYSPRING DENTAL

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Please check all that apply)

- ▢ Cell Phone
  - ▢ OK to receive text messages
  - ▢ OK to leave voicemail with detailed information
  - ▢ Leave voicemail with call-back number only
- ▢ Home Phone
  - ▢ OK to leave message with detailed information
  - ▢ Leave message with call-back number only
- ▢ Written Communication
  - ▢ OK to mail to my home address
  - ▢ OK to mail to my work/office address
  - ▢ OK to fax to this number _____
- ▢ Other _____

_____ _____

Patient's Signature Date

_____ _____

Print Name D.O.B

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

DAYSPRING DENTAL

PATIENT RECORD OF DISCLOSURES (CONT)

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

DATE	DISCLOSED TO WHOM ADDRESS/FAX NUMBER	DESCRIPTION OF DISCLOSURE/PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED