

Patient's Name: _____ Preferred Name: _____

(Last) (First) (MI)

Status: Married Single Minor

Gender: Male Female

Date of Birth: _____ Social Security # _____ Parent/Guardian (If Minor) _____

Address: _____
(Street) (City) (State) (Zip)

Home #: _____ Cell #: _____ Work #: _____ Employer: _____

Email: _____

Emergency Contact: _____

Preferred appointment time: Morning Afternoon

Relationship: Parent Spouse Family Friend Other

Preferred appointment day: M T Th

Phone #: _____

Primary Dental Information

Secondary Dental Information

Insurance Co. _____

Insurance Co. _____

Insurance phone # _____

Insurance phone # _____

Employer: _____

Employer: _____

Group Number: _____

Group Number: _____

Subscriber ID or SS # _____

Subscriber ID or SS # _____

Subscriber Name: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Date of Birth: _____

I authorize payment directly to **W.Randall Cline, D.D.S.**, of insurance benefits otherwise payable to me. I understand that my dental insurance or carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

Patient / Guardian Signature: _____ **Date:** _____

To the best of my knowledge, all of the information provided above is true and correct.

Patient / Guardian Signature Date _____

Whom may we thank for referring you to our practice?

- Yellow Pages
- Direct Mail
- Other _____
- Internet
- Walk-In
- Another Patient _____

Patient Name: _____

Birth Date: _____ Date Created: _____

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes _____
- Have you ever been hospitalized or had a major operation? Yes No If yes _____
- Have you ever had a serious head or neck injury? Yes No If yes _____
- Are you taking any medications, pills, or drugs? Yes No If yes _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No

Women: Are you...

- Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

Do you use controlled substances? Yes No If yes _____

Do you have, or have you had, any of the following?

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problems <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed Yes No If 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: _____

X _____ Date: _____

CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist’s advice and recommendations regarding medication, pre-and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

Do not consent to treatment until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment you signal your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

In the event that W. Randall Cline D.D.S., or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

In an effort to control the increasing cost of dental care, any claims or disputes against this office shall be resolved by “binding arbitration”. By signing this agreement, the patient agrees with the office of Dr. Randall Cline, that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement including associates) shall be resolved by binding arbitration, by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge, and agrees that all such claims will be resolved as described in this section.

Patient Signature

Date

CONSENT TO LOCAL ANESTHESIA

I hereby authorize Dr. Randall Cline, to administer local anesthesia to me. I have been informed of the usual side effects and have been informed of the advantages and disadvantages of anesthesia. I understand the risk of reactions, such as redness, swelling, pain, itching, vomiting, anaphylactic shock and/ or permanent nerve damage or other unforeseeable complications which may result from the administration of anesthetics. I realize that in spite of the possible complications, the use of anesthesia is necessary and desired by me.

Patient Signature

Date

Marshville Family Dentistry

HIPPA OMNIBUS RULE **Patient Acknowledgement of receipt** **Of notice of privacy practices and consent/limited authorization** **& release form**

You may refuse to sign this acknowledgement & authorization. In refusing We MAY NOT BE ALLOWED TO PROCESS YOUR INSURANCE CLAIMS.

Please print your name: _____

The undersigned acknowledges receipt of a copy of the currently effective notice of privacy practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ (Initial here) Acknowledge that Marshville Family Dentistry corresponds electronically and /or over the phone with referral doctors with health information.

Please list any other parties who can have access to your health information:
(This includes spouse, friend, care taker or family member ie; parent, step parent, child, or grandparent,)

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I authorize contact from this office to Confirm my Appointment, Treatment, & Billing Information VIA:

- Cell phone confirmation
- Home phone confirmation
- Work phone confirmation
- Email confirmation
- Any of the above

In signing this HIPPA patient acknowledgement form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPPA Omnibus rule, provide you this information with your knowledge and consent.

You may revoke this authorization in writing or by updating this form.

Patient Signature

Date

Legal Representative

Description of Authority

OFFICE FINANCIAL POLICY

PATIENTS WITH INSURANCE

We will provide you with an *estimate* of the total fee expected. Your estimated portion is due in full the day of treatment. As a courtesy, we will file your insurance. **If after 40 days we have not received payment from your insurance company, the balance becomes your responsibility.** We will bill you and allow you 15 days to settle your account.

When estimating insurance coverage, we stress the word *estimate* as dental benefits are determined by each patient’s dental contract. Insurance is a contract between **you and your insurance company**. We are not a party to that contract.

Initial _____

PAYMENT OPTIONS

We understand that it may be difficult to afford out-of-pocket care. For your convenience, we offer the following payment option:

- **Cash**
- **Check** (\$30 charge for all returned checks)
- **Visa, Master Card, Discover**
- **Monthly Payments** (Short-term and long-term financing through **Care Credit** a dental payment plan with no interest plans for up to 12 months*)

CANCELLATION AND TARDY POLICY - 24-HOUR CANCELLATION POLICY

We recognize that unexpected things come up for all of us but, as a courtesy to our other patients and our staff, we require that you cancel any appointment with a **minimum of 24 hours notice**. Sufficient notice allows us to fill the open appointment time with another patient needing treatment. Leaving a message after hours on our voice mail does not allow us enough time to reschedule. **Once a spot is reserved, IT IS YOUR SPOT!**

Please note that we charge a \$50.00 late cancellation or no show fee.

Initial _____

In addition, if something unforeseen arises and you are going to be **more than 15 minutes late for your appointment** we will consider this a late cancelation and ask that you reschedule your visit. We understand that people get delayed by circumstances beyond their control but one late patient can mean all subsequent patients scheduled that day are delayed.

Our goal is to be respectful of all our patients and their needs. We appreciate your cooperation with our policies.

Signature of Patient/Guardian

Date