Welcome to our Practice!

Please take a few minutes to complete the following CONFIDENTIAL information. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Legal Name_____ **DOB**_____

Name You Wish To Be Called_____ **SS#**_____

Address_____ **City / Zip Code**_____

Phone (H)_____ (W)_____ (C) _____

E-mail Address_____

Sex ☐F ☐M **Marital Status** ☐S ☐M ☐D ☐W **Driver's License #**_____ **State**____

How did you hear about our office? _____

Is Another Member of Your Family a Patient? ☐Yes ☐No **If so, name** _____

In case of emergency who should be notified? _____ **Phone**_____

What time of the day is the best time to reach you at home_____ **work**_____?

Spouse / Parent Information

Person responsible for account _____ **SS#** _____

Parent ☐ **Spouse** ☐ **Guardian** ☐ **Driver's License #**_____ **State**____

Address (if different)_____

Phone (H)_____ (W)_____ **Employer**_____

Patient Employer Information

Employer_____ **Occupation**_____

Employer Address _____

Phone_____ **Fax**_____ **Is it okay for us to contact you at work?** _____

Appointment Information

Do you have special needs we should consider when scheduling your appointment? ☐ Yes ☐ No
if so, explain_____

Do you prefer your appointments to be scheduled in the ☐ **morning** ☐ **afternoon?**
(Certain procedures must be scheduled at times designated by Dr. Pybus. But, some appointments can be scheduled to best fit your preferred times.)

What pharmacy do you prefer?_____ **Phone**_____

Primary Insurance Information

Name of Insured _____ **Relationship** ☐ Spouse ☐ Child ☐ Self

Insured's SS# _____ **Insured's DOB** _____

Insured's Employer _____

Insurance Company Name _____ **Group #** _____

Address _____

Phone _____ **Fax** (if known) _____

We are happy to file your insurance for you. However, our relationship is with you, our patient, and not with your insurance company. The balance for services rendered by our office ultimately belongs to you regardless of your estimated insurance benefits.

Secondary Insurance Information

Name of Insured _____ **Relationship** ☐ Spouse ☐ Child ☐ Self

Insured's SS# _____ **Insured's DOB** _____

Insured's Employer _____

Insurance Company Name _____ **Group #** _____

Address _____

Phone _____ **Fax** (if known) _____

We are happy to file your insurance for you. However, our relationship is with you, our patient, and not with your insurance company. The balance for services rendered by our office ultimately belongs to you regardless of your estimated insurance benefits.

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Pybus to make a thorough diagnosis of (patient) _____'s dental needs.

2. Upon such diagnosis, I authorize Dr. Pybus to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in advance with the Financial Coordinator. In the event that payments are not received by agreed upon dates, I understand that a 1 - 1.5% late charge may be added to my account. I understand that I am responsible for the total amount of my dental treatment regardless of my personal insurance benefits.

Signature of Responsible Party _____ **Date** _____

Patient Name: _____

DENTAL HISTORY

Welcome! Please complete both sides of this dental/medical history form so that we may create a treatment plan specialized for your individual needs. All information will be kept strictly confidential.

What is the reason for today's visit? _____

Date of Your Last Dental Visit? _____ **Last Professional Dental Cleaning** _____
Last Full Mouth Series of X-rays (18 small films) _____
What was done at your last dental visit? _____
Previous Dentist's Name _____ City _____

How often do you have dental examinations? _____ Professional Cleaning? _____
How often do you brush your teeth? _____ How often do you floss your teeth? _____
What other dental aids do you use to clean your teeth? (Interplak, toothpick, etc.) _____

Do you have any dental problems right now? _____ How long has your dental problem bothered you? _____
Please describe: _____
_____

Does having dental treatment make you afraid or nervous? Yes No If yes, what specific things bother you? _____
_____

Are any of your teeth sensitive to:
Hot temperatures? Yes No Does it linger? Yes No
Cold temperatures? Yes No Does it linger? Yes No
Sweets? Yes No
Biting or chewing pressure? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters, or any other oral lesion? Yes No

Do your gums bleed or hurt (when brushing)? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No
Where? _____

Are you allergic to: Metals? Yes No
Some Jewelry Yes No
Acrylic? Yes No
Artificial Fingernails? Yes No

Are you happy with the appearance of your teeth? Yes No

Have you ever had:
Orthodontic treatment (braces)? Yes No
Oral Surgery? Yes No
Periodontal treatment (gum treatment)? Yes No
Your teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
Please describe: _____

Have you experienced:
Clicking or popping of the jaw? Yes No
Pain (joint ear, side of face)? Yes No
Difficulty opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neck aches, or shoulder aches? Yes No
Dry mouth? Yes No

Do You:
Clench or grind your teeth while awake or asleep? Yes No
Have a family member that clenches or grinds? Yes No
Have tired jaws or headaches, especially in the morning? Yes No
Smoke/chew tobacco? Yes No

Would you like to keep your teeth all of your life? Yes No
If you could change anything about your smile, which of the following would you want?

Whiter	Straighter	Close Space or Spaces	Replace Missing Teeth
Less Gum Showing	Replace Old Crowns	Excess Showing of Teeth	Replace Old Plastic Fillings
Reshape/resize my Teeth	Replace Chipped Teeth	Remove Silver Fillings	Remove Stains/Spots on Teeth

Please circle the following which are important to you when making your dental health decision.

Convenience	Appearance	Relationship with Dental Team	Finances
Time	Quality of Care	Detailed Treatment Explanations	What Insurance Covers
Fear or Anxiety	Comfort	Technology	Health

MEDICAL HISTORY

Patient Name: _____

1) Have you been under a physician's care in the past two years..... Yes No
2) If yes, for what? _____
3) Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
4) Have you taken any medication during the past two years..... Yes No
5) Are you currently taking any medications (including over-the-counter drugs or herbal remedies)..... Yes No
6) If yes, please list medication and dosage _____
   _____
7) Have you ever had an allergy or reaction to acrylic (including artificial fingernails)?..... Yes No
8) Have you ever had an allergy or reaction to metals (jewelry, etc.)?..... Yes No
9) Have you ever had an allergic (or adverse) reaction to any medication (including over-the-counter drugs) or any other substance not listed above?..... Yes No
10) If yes, please list medication or substance: _____
11) Have you been hospitalized during the past five years?..... Yes No
12) Have you **ever or are currently** taking oral or IV medication to prevent the loss of bone density? Yes No
13) Please indicate which of the following you have had or currently have from the list below. Circle each answer:

Heart Disease, Heart Surgery, Heart Attack	Tuberculosis	Sleep Apnea
Chest Pain	Asthma	Bruise Easily
Congenital Heart Disease	Latex Allergy or Sensitivity	Liver Disease
Heart Murmur	Allergies or Hives	Yellow Jaundice
High Blood Pressure	Sinus Trouble	Neurological Disorders
Mitral Valve Prolapse	Radiation Therapy	Epilepsy
Artificial Heart Valve	Chemotherapy	Seizure Disorders
Heart Pacemaker	Tumors	Fainting or Dizzy Spells
Rheumatic Fever	Hepatitis A (infectious)	Nervous/Anxious
Arthritis/Rheumatism	Hepatitis B (serum)	Psychiatric/Psychological Care
Stroke	Hepatitis C	Diabetes
Artificial Joints (hip, knee, etc.)	Herpes	Emphysema
Kidney Disease/Trouble	A.I.D.S.	Substance Abuse Problem
Ulcers	H.I.V. Positive	Headaches
Dry Mouth		

13) Do you use more than one pillow to sleep at night?..... Yes No
14) Do you have or have you had any disease, condition, or problem not listed above?..... Yes No
15) If yes, please list: _____
16) **Woman:** Are you: **Pregnant**? Yes, _____Months No **Nursing**? Yes No
Planning Pregnancy? Yes No **Taking birth control pills**? Yes No

I understand that the above information is necessary in order to provide me with safe dental care. I have answered all questions to the best of my knowledge. Should further information be needed for my dental treatment or to fully understand any health condition I may have, I give my permission to contact my health care provider or agency who may release such information to this office. I will notify Dr. Pybus of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist's Signature _____ Date _____

Financial Philosophy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Philosophy, which we require you read and sign prior to any treatment.

All patients must complete our demographic form, health / dental history forms and this financial philosophy before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. ANY FINANCIAL ARRANGEMENTS MADE WILL INCLUDE A CREDIT REPORT. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CARECREDIT, AND CHASE HEALTH ADVANCE..

We may accept assignment of insurance benefits after your second visit. However, we do require at least your estimated portion to be paid at the time of service. **The balance is your responsibility whether your insurance company pays or not.** We cannot file your insurance unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We file your insurance as a courtesy. In the event that your insurance does not pay within 60 days, the balance will be transferred to the patient. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance policy.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and our fees are usual and customary for our office. Our fees are based on the education of our staff, the high quality of materials and labs used, state of the art equipment used and procedures performed. Should you accept treatment, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

Secondary Insurance: Having more than one insurer does not necessarily mean that your services are covered at 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your primary insurance has cleared.

Minor Patients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minor, non-emergency treatment will be denied unless prior payment arrangements have been made.

Divorce Decree: This office is NOT a party to your divorce decree. Parents are responsible for their bill at the time of service. **THE ACCOMPAYNING ADULT IS RESPONSIBLE FOR THE MINORS ACCOUNT.**

Missed Appointments: Unless cancelled, at least 48 hours in advance, our policy is to fee for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Interest: We reserve the right to charge interest in the amount of 1.5% as approved by state law.

Thank you for understanding our Financial Philosophy. Please let us know if you have any questions or concerns. I have read, understand and agree to this Financial Philosophy.

_____ _____

Signature of Patient or Responsible Party Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health/dental information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health/dental information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change these practices from time to time and that I may request, at any time at the address below, a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (print): _____

Signature: _____

Relationship To Patient: _____

Date: _____

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