Welcome Packet

Name:_____ DOB:__/__/__ SSN:_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

How would you prefer to be contacted: ☐Email ☐Text ☐Phone (you may check more than one)
Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced

Whom may we thank for referring you to us?_____

Responsible Party (Who is responsible for any costs incurred)

Name:_____ DOB:__/__/__ SSN:_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Relationship to patient: Self ☐ Spouse ☐ Parent ☐ Other ☐

Fenton Family Dentistry is dedicated to the best quality, service, and comfort available. In return, we expect payment at the time of service. If you are unable to meet your obligation to this practice, please ask about payment plan options before being seen. I understand and agree that regardless of my insurance status or marital status, I am ultimately responsible for the balance of my, the patient's, account for all professional services rendered and any costs incurred as a result of not meeting my obligations. I authorize this office to submit insurance claims on my behalf. I certify that this information is true and correct to the best of my knowledge.

Signature:_____ Date:_____

Parent or legal guardian signature if the patient is a minor

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Help Us Help You

What can we do for you?

Type in your answers here:

What is most important to you while you are in our care?

Type in your answers here:

What type of care would you like to receive? (Check all that apply)

Cosmetic Care that improves your smile, overall appearance, and self-confidence. ☐

Proactive Care that improves and maintains your overall oral health. ☐

Maintenance Care that treats issues only when absolutely necessary. ☐

Emergency Care that gets you out of pain. ☐

Dental Insurance

As a courtesy, we offer many different opportunities to help you maximize your insurance benefits without sacrificing the quality of your care. Many patients have dental insurance and use it to supplement the cost of their dental care. As a courtesy, we can submit and process all your claims. Please make sure we have a copy of your current insurance card on file. If you are a full-time student, we will also need a copy of your student ID.

Primary Dental Insurance:

Name of Insured:_____ Relation to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured SSN:_____ Insured DOB:__/__/__

Employer:_____ Insurance Company:_____

Insurance Group Number:_____

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Secondary Dental Insurance:

Name of Insured:_____ Relation to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured SSN:_____ Insured DOB:__/__/__

Employer:_____ Insurance Company:_____

Insurance Group Number:_____

Medical History

Your overall health and safety are of paramount importance to us. It is critical that we know all your medical information no matter how non-pertinent you may feel it is. The information obtained is completely confidential. The relationship between your mouth and your entire body should not be underestimated. Please be upfront and honest in order to avoid complications and risk to your oral wellbeing and overall health.

Emergency Contact:_____ Phone number:_____

Do you have any of the following diseases or problems: **Check all that apply**

Active Tuberculosis ☐
Persistent cough greater than 3 week duration ☐
Cough that produces blood ☐
Been exposed to anyone with tuberculosis ☐

Are you now under the care of a physician? ☐Yes ☐No

Physician Name:_____

Phone Number:_____ Date of last physical exam:_____

Are you in good health? ☐ Yes ☐ No
Any change in your health over the last year? ☐ Yes ☐ No
If yes, what is being treated?_____
Have you been hospitalized in the past 5 years? ☐ Yes ☐ No
If yes, what was being treated?_____

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List all prescription medications, over-the-counter medications, vitamins, herbal supplements, or diet supplements. If you are not taking anything, please write none.

Type in your answers here:

Have you had a joint replacement? ☐ Yes ☐ No
Date placed: ☐/☐/☐

Are you taking or scheduled to begin taking alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you scheduled to begin treatment with the IV bisphosphonates (Aredia or Zometa) ☐ Yes ☐ No
If yes, date treatment began: ☐/☐/☐

Do you use controlled substances? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you drink alcoholic beverages? ☐ Yes ☐ No

WOMEN ONLY:

Are you pregnant? _____ If yes, number of weeks? _____
Are you taking birth control or hormone replacements? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No

Allergies **Check all that apply**

Local anesthetics ☐
Aspirin ☐
Penicillin or other antibiotics ☐
Barbiturates, sleeping pills, sedatives ☐
Sulfa Drugs ☐
Metals ☐
Iodine ☐
Hay fever/seasonal ☐
Animals ☐
Food ☐
Codeine ☐
Latex ☐
Other: _____

Congenital Heart Disease-Please check if you have any of the following:

Artificial valve ☐
Previous infective endocarditis ☐
Repaired CHD with residual effects ☐
Unrepaired, cyanotic CHD ☐
Damaged valves in heart transplant ☐
Congenital heart disease ☐

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Other Diseases and Conditions-Please circle if you have or have had any of the following:

Cardiovascular disease ☐
Angina ☐
Arteriosclerosis ☐
Congestive heart failure ☐
Damaged heart valves ☐
Heart attack ☐
Heart murmur ☐
Low blood pressure ☐
High blood pressure ☐
Other congenital heart defects ☐
Mitral valve prolapse ☐
Pacemaker ☐
Rheumatic fever ☐
Rheumatic heart disease ☐
Abnormal bleeding ☐
Chest pain upon exertion ☐
Chronic pain ☐
Diabetes ☐
Eating disorder ☐
Malnutrition ☐
GI disease ☐
Acid reflux/persistent heartburn ☐
Thyroid problems ☐
Stroke ☐
Glaucoma ☐
Hepatitis, jaundice, liver disease ☐
Epilepsy ☐
Fainting spells or seizures ☐
Neurological disorders ☐

Anemia ☐
Blood transfusion ☐
If yes, date:__/__/__
Hemophilia ☐
AIDS or HIV ☐
Arthritis ☐
Autoimmune disorder ☐
Rheumatoid arthritis ☐
Systemic lupus erythematosus ☐
Asthma ☐
Bronchitis ☐
Emphysema ☐
Sinus trouble ☐
Tuberculosis ☐
Cancer/chemotherapy/radiation ☐
If yes, please specify:_____
Sleep disorder ☐
Mental health disorders ☐
If yes, please specify:_____
Recurrent infections ☐
Type of infections:_____
Kidney problems ☐
Night sweats ☐
Osteoporosis ☐
Persistent swollen glands in neck ☐
Severe headaches/migraines ☐
Severe or rapid weight loss ☐
Sexually transmitted diseases ☐
Excessive urination ☐

Please list any disease, problem, or condition that is not listed above:_____

Premedication Has a physician or previous dentist recommended that you take antibiotics prior to dental visits? ☐Yes ☐No

Name of physician or dentist making the recommendation:_____

The medical questions above have been accurately answered to the best of my knowledge. I acknowledge that I understand providing misleading or incorrect information can be dangerous to my health. It is my responsibility to inform Dr. Nieva and the FFD team of any changes in my medical status and/or medications.

Signature:_____Date:__/__/__

Parent or legal guardian signature if the patient is a minor.

Image Release

We are very proud of the quality of care we provide. We love to show and tell our current and potential patients the amazing work we have done for you. With your consent we would use images to inform and educate on our website, social media accounts and other marketing materials. However, we understand and respect your privacy. You are under no obligation to consent to a release, nor will it impact your care, or any fees associated with your treatment.

Please check the release you are most comfortable with:

☐ I give FFD permission to use my images for their website, social media accounts and marketing materials.

☐ I do not give FFD permission to us my images.

I understand that I may revoke this authorization by written notice. Revocation only applies to new uses of any release images and cannot recall prior uses. I also understand that there is no compensation for the use of my images.

Signature:_____ Date: ☐/☐/☐

Parent or legal guardian signature if the patient is a minor

Financial Agreement

Fenton Family Dentistry's goal is to help you establish excellent oral health. We are committed to helping you determine the most appropriate treatment for your dental needs and desires. Should you have questions concerning your treatment, treatment sequence, or fees for services, please ask for clarification before treatment has begun.

Our financial policy is as follows:

- We accept cash, personal checks, and most major credit cards including MasterCard, VISA, and Discover.
- A $35.00 fee will be applied for ALL returned checks.
- Payment is due at the time of service.
- Payment plans for certain procedures are available through CareCredit with payment options available for up to 5 years at fixed rates.
- Insurance- insurance is a contract between the patient and/or employer and the insurance company. It is not a contract between our office and your insurance company. As a courtesy, we will be happy to assist you by filing your insurance claim and answering the details that the insurance company may require. We cannot be responsible for payment by the insurance company. The responsibility for payment belongs to the patient.
- We will provide estimated balances between the cost of service and co-payment of your insurance. Predetermination of benefits may be advisable if there is a question concerning coverage.
- We will accept assignment of benefits subject to verification of insurance coverage.
- Extended treatment plans will be outlined so that appropriate payments may be made as each phase of treatment has begun.

We reserve the right to accept or deny certain insurance plans at our discretion. If we accept your insurance plan, our estimation of your co-payment is due at the time of service. If your insurance company has not paid the *full balance* within 90 days, you will have 60 days to pay the balance.

Should your insurance be denied, full payment is expected at the time of service unless prior arrangements have been made through our office manager.

Please remember that you are responsible for timely payment to your account. Should it become necessary to refer your account to an agency or attorney for collection, you will also be responsible for all costs associated with the collection including attorney's fees and court costs.

I understand the above policy and agree to the terms herein.

Signature:_____ Date: ☐☐/☐☐/☐☐

Parent or legal guardian signature if the patient is a minor

HIPAA Release

I,_____, authorize the release of **ALL** my HIPAA protected information to:_____
I understand that this includes financial, scheduling, and medical information. I also understand that I may alter this declaration by submitting a written request. I authorize the above person(s) to make scheduling, treatment, and financial arrangements on my behalf.

☐ I authorize Fenton Family Dentistry to leave a message regarding any of my financial, scheduling, and medical information.

Phone number:_____

☐ I authorize Fenton Family Dentistry to email any of my financial, scheduling, and medical information.

Email:_____

☐ I do not wish to share any of my HIPAA protected information with anyone.

I understand that I will still be financially responsible for any treatment performed, or products supplied to me.

Signature:_____ Date:☐☐/☐☐/☐☐

Parent or legal guardian signature if the patient is a minor

Cancellation and No Show Information

We do our very best to value and respect your time and we require the same courtesy in return.

Our view: An appointment made is a commitment between you, the patient, and us. It is reserving a time in our schedule for you and your dental needs. That reservation limits access for needed and wanted care for other patients. While we understand the many priorities we all face in today's hectic world, we count on you to honor your obligation of time with us.

Our expectations and your obligation: Any appointment made will be confirmed 2 business days in advance by phone, email, or text. An appointment canceled or rescheduled within 2 business days or less or an appointment that is missed will be considered a cancellation or no show.

Although we prefer not to, we reserve the right to charge for such appointments. These charges range from $50 per hour scheduled to the anticipated fees for the procedures that would have been performed. We do everything to avoid this unpleasantry and we ask that you do the same.

I have reviewed the above information and all my questions have been answered to my satisfaction. All changes to the policies listed in this packet will be posted in our waiting room and will apply.

Signature:_____ Date: ☐/☐/☐

Parent or legal guardian signature if the patient is a minor