Welcome

Thanks for choosing Open Door Family Dentistry, we are here when you need us.

About you

Name: _____ Date: _____

I prefer to be called: _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Child

Home Phone #_____ Cell Phone #_____

Email Address: _____

Birthdate: ___/___/_____Age: _____ Soc. Sec# _____

Address: _____

City: _____ State: _____ Zip code: _____

Patient's or Parent's Employer_____ Work Phone #_____

Business Address: _____ City: _____ State: ____ Zip: _____

Person to contact in case of an emergency: _____ Phone #_____

How did you hear about our practice? _____

Are you happy with the appearance of your smile? _____

If not, what would you like to see changed? _____

Helping people live longer, happier lives!

Health History

Name:_____ Birthdate:____/_____/_____

OPEN DOOR DENTAL

Are you required to pre-medicate with an antibiotic before dental treatment?	☐	☐
Have you ever taken a bisphosphonate medication? (Usually used to treat bone cancer or osteoporosis)	☐	☐
Are you currently taking a blood thinner?	☐	☐
Are you currently pregnant or breastfeeding?	☐	☐
Do you smoke?	☐	☐
Allergies to medications?	☐	☐
If yes, what?		
Are you currently taking any medications?	☐	☐
Please list medications:		
Have you been under the care of a physician in the last 5 years?	☐	☐
If yes, what is the reason for care?		
Physicians currently providing your care: **Name:** **Phone #:** **Name:** **Phone #:**		

Please circle yes if you've experienced these conditions:

Heart (circle one: Surgery, Disease, Attack)	☐	**Cancer**	☐
Epilepsy	☐	**Other Infections**	☐
Hepatitis, any form	☐	**Recurrent Illness**	☐
Asthma	☐	**Joint Replacement**	☐
HIV or AIDS	☐	**Liver Disease (including Jaundice)**	☐
Emphysema, COPD other Respiratory Illness	☐	**Abnormal Bleeding from a Cut**	☐
Kidney Disease	☐	**Unintentional Weight Gain/Loss**	☐
Diabetes	☐	**Illegal Drug Use**	☐
Hemophilia	☐	**Hypertension (High Blood Pressure)**	☐

This office uses nitrous oxide during some dental procedures for relaxation and to ease anxiety. Certain medications and medical conditions may interfere with the effectiveness of nitrous. Some patients while on nitrous can experience nausea, dizziness, drowsiness or may feel claustrophobic. The recovery time from nitrous is rapid and you are not required to have a driver. Nitrous is not covered by insurance and is $83.00, which is due on the date the nitrous is administered. Further details will be given upon request.
I understand the above statement and have no further questions should I choose to move forward with nitrous oxide treatment.

Signature_____ Date_____

Responsible Party

Name of person responsible for this account:_____

Relationship to patient:_____

Address:_____ City:_____ State:_____ Zip: _____

Home Phone#:_____Cell Phone#: _____

Birthdate:____/____/_____ Soc.Sec.#_____ ☐ Single ☐ Married ☐ Child

Driver's License#: _____ Employer:_____ Work Phone: _____

Insurance Information

Subscriber:_____Relationship to Patient:_____

Birthdate:____/____/_____ Soc.Sec.#:_____ Date Employed: _____

Name of Employer:_____ Union or Local #:_____ Phone #:_____

Insurance Company:_____ Group#:_____ Policy#: _____

Address:_____ City:_____ State:_____ Zip: _____

Do you have a secondary insurance? ☐ Yes ☐ No If yes, please complete the following:

Subscriber:_____ Relationship to patient: _____

Birthdate:___/___/_____ Soc.Sec.#:_____ Date Employed: _____

Name of Employer:_____ Union or Local#: _____ Work Phone: _____

Revolutionizing dentistry, by adapting dental hygiene services to actually meet people's need.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the doctors and/or his staff to disclose specific health and dental information regarding:

_____

(Name of Patient)

To: (Ex: friend/family member that might request information)

_____

_____

_____

For the purpose of scheduling, diagnosing, and resolution of the account and treatment.
By initialing the spaces below, I specifically authorize the release of the following information:

_____ Diagnosis of treatment

_____ Account resolutions

_____ Scheduling appointments

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____

(Name of Patient)

_____

(Signature)

_____

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgment.

_____ Other (Please Specify)

Authorization and Release

I authorize the dentist or staff to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Collection Fee Policy

You are financially responsible for the timely payment of your outstanding bill per our payment policies. You will be responsible for any and all collection agency fees up to $200. In the event we seek legal action for collection on your accounts, you will also be responsible for any and all fees associated with court costs, garnishment and/or attorney fees. A finance charge of 9% annual interest will be charged monthly on any account balance over 90 days. For any payment plan over 90 days there will be 9% annual interest on the payment plan total from the start of the payments.

Signature: _____ Date: _____