HOW DID YOU HEAR ABOUT US? ☐ **GOOGLE** ☐ **INSURANCE PROVIDER** _____

☐ **BILLBOARD** ☐ **REDWOOD WEBSITE** ☐ **YELLOWPAGE ONLINE** ☐ **FRIEND** ☐ **RELATIVE** ☐ **OTHER**_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? *Circle one:* MR MRS MS MISS DR **NAME:**

ADDRESS:	E-MAIL ADDRESS:
CITY, STATE:	BIRTH DATE: / / SEX: M F
ZIP CODE:	SOCIAL SECURITY NO.: - -
HOME PHONE:	**EMPLOYER:**
WORK PHONE:	EMERGENCY CONTACT:
CELL #:	NAME _____
Method of Payment: Insurance ☐ Cash/Check ☐ Credit Card ☐	PHONE # _____

DENTAL INSURANCE PRIMARY COVERAGE

EMPLOYEE NAME:	
ADDRESS:	
CITY, STATE:	
ZIP CODE:	
HOME PHONE:	
WORK PHONE:	
BIRTH DATE: / / SEX: M F	
SOCIAL SECURITY NO.: - -	
EMPLOYER:	
INSURANCE NAME:	
INS. ADDRESS:	
GROUP # OR LOCAL #:	
SUBSCRIBER #:	

DENTAL INSURANCE SECONDARY COVERAGE

EMPLOYEE NAME:	
ADDRESS:	
CITY, STATE:	
ZIP CODE:	
HOME PHONE:	
WORK PHONE:	
BIRTH DATE: / / SEX: M F	
SOCIAL SECURITY NO.: - -	
EMPLOYER:	
INSURANCE NAME:	
INS. ADDRESS:	
GROUP # OR LOCAL #:	
SUBSCRIBER #:	

MEDICAL INSURANCE PRIMARY COVERAGE

INSURANCE NAME:	
INS. ADDRESS:	
GROUP #:	
SUBSCRIBER #:	

MEDICAL INSURANCE SECONDARY COVERAGE

INSURANCE NAME:	
INS. ADDRESS:	
GROUP #:	
SUBSCRIBER #:	

The account holder is responsible for all account balances older than 90 days, regardless of insurance coverage or reimbursement status. All account balances 90 days and older will accrue a late payment charge of 2% monthly.

If account enters collection, a 21% collection fee will be added to the balance.

Your insurance policy is a contract between you and your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at time of service. We accept cash, checks and most major credit cards.

Any missed appointments without 24 hours notice, except in an emergency, will result in a charge to the patient. These charges are due and payable within 30 days.

I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

RESPONSIBLE PARTY SIGNATURE _____ DATE: ___/___/___

PATIENT ACCOUNT REGISTRATION **NAME**_____**D/O/B**_____

INSURANCE/ ACCOUNT AGREEMENT

Effective January 1, 2019

- If you have dental insurance, a portion of your fees will most likely be covered by your insurance. It is your responsibility to obtain the benefits entitled to you.

- Dental insurance is a contract between you and your insurance carrier, not between the insurance carrier and this office. While we will assist you in receiving the maximum insurance benefit allowable, our office cannot guarantee that your insurance company will pay for treatment you receive from our practice. Should your claim be denied you will be responsible for payment in full at that time.

- Insurance payments are usually received within 30-60 days from the time the claim is submitted. Should your insurance company not reimburse our office within 60 days, we ask that you pay the balance at that time and seek reimbursement from your insurance company yourself.

- While our office will not enter into disputes over claims with insurance companies, we will gladly provide any additional information they may request. The ultimate responsibility for resolution of dispute lies with you, the patient.

- Unless you intend to pay in full for treatment as it is rendered, our office policy requires that the patient assign payment of the allowable insurance payments to our office by signing the agreement below.

- If you do not have dental insurance, payment for services is expected at the time of service.

- In cases where all parties of a family (wife, husband, kids, etc.) are on the same account any balance left will be collected at the visit of whomever is scheduled next unless paid prior. *Ex: Mrs. Smith was seen a month ago, and there is a balance left for that visit of $40.00. Mr. Smith is scheduled to come in next week. At that time Mr. Smith will be responsible for the balance and any co-pay he may have for his appointment.* If you have any questions please refer to the front desk.

I hereby authorize assignment of payment of my dental insurance benefits to **Dr. Joseph S. Arnold, D.D.S., P.C.** This Assignments of Benefits shall be deemed ongoing until my dental insurance carrier receives written notice from me that I have revoked this agreement. I also, agree to all statements listed above.

_____ _____

Patient/ Parent Guardian Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

For office use only:

Patient refused to sign. The following circumstances prohibited the patient from signing the acknowledgment:

_____

_____ _____

Office Personnel (signature) **Office Personnel (print)**

Date: _____

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient Name: _____ Date of Birth _____ Age:_____ ☐ Male ☐ Female

Address _____ Weight _____ Home Phone No. _____

_____ Height _____ Work Phone No. _____

_____ SSN # _____ Cell Phone No. _____

If you are completing this form for another person, what is your relationship to that person? Your Name _____ Relationship _____

MEDICAL HISTORY

Physician's Name _____

Address _____

Are you now under the care of a physician? YES ☐ NO ☐

If yes, for what reason? _____

Are you presently taking any medications / drugs / pills? YES ☐ NO ☐

List all medications prescribed by your physician (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances.

ALLERGIES / SENSITIVITIES:

Are you allergic / sensitive (or ever had an adverse reaction) to: *Check all that apply or check none*

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Metals ☐ LATEX

☐ Aspirin ☐ Other Antibiotics ☐ Other Medications or Substances ☐ **NONE**

Do you have, or have you ever had any of the following: (YES or NO)

	YES	NO		YES	NO		YES	NO		YES	NO
1 Artificial (prosthetic) heart valve	☐	☐	13 Anorexia	☐	☐	29 Drug Dependency	☐	☐	45 Autoimmune Disease	☐	☐
2 Previous infective endocarditis	☐	☐	14 Bulimia	☐	☐	30 Chemical Dependency	☐	☐	46 Artificial Joint / Prosthesis	☐	☐
3 Damaged valves in transplanted heart	☐	☐	15 Lung disease / COPD	☐	☐	31 Blood Disorders	☐	☐	47 Liver Disease	☐	☐
4 Congenital heart disease (CHD)			16 Tuberculosis	☐	☐	32 Anemia	☐	☐	48 Hepatitis (circle one)	☐	☐
Unrepaired, cyanotic CHD	☐	☐	17 Asthma	☐	☐	33 Leukemia	☐	☐	Type A B C Other		
Repaired (completely) in last 6 months	☐	☐	18 Shortness of Breath	☐	☐	34 Prolonged Bleeding	☐	☐	49 Ulcers	☐	☐
Repaired CHD with residual defects	☐	☐	19 Respiratory Ailments	☐	☐	35 Hemophilia	☐	☐	50 Gastrointestinal Disease	☐	☐
5 Heart Disease/Surgery	☐	☐	20 Emphysema	☐	☐	36 Sickle Cell Disease	☐	☐	51 GERD (gastric reflux)	☐	☐
6 Heart murmur	☐	☐	21 Sinus Trouble	☐	☐	37 Cancer	☐	☐	52 Hard of Hearing	☐	☐
7 Heart pacemaker	☐	☐	22 Diabetes Type I or Type II	☐	☐	38 Tumors	☐	☐	53 Glaucoma	☐	☐
8 Rheumatic fever/heart disease	☐	☐	23 Thyroid Problems	☐	☐	39 Chemotherapy	☐	☐	54 Cortisone Medication	☐	☐
9 Mitral valve prolapse	☐	☐	24 Persistent swollen glands	☐	☐	40 Radiation Therapy	☐	☐	55 Fainting Spells	☐	☐
10 High/low blood pressure	☐	☐	25 Kidney Problems	☐	☐	41 Neurological Disorders	☐	☐	56 Organ Transplant	☐	☐
11 Learning Disability	☐	☐	26 Venereal Disease	☐	☐	42 Epilepsy	☐	☐	57 Removal of Spleen	☐	☐
12 Mental Health Disorder	☐	☐	27 HIV Positive / AIDS / ARC	☐	☐	43 Stroke	☐	☐	58 Osteoporosis	☐	☐
			28 Alcohol Addiction	☐	☐	44 Arthritis / Rheumatism	☐	☐	59 Sleep Disorder	☐	☐

BISPHOSPHONATES

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for **osteoporosis** or Paget's disease? ☐ YES ☐ NO

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ YES ☐ NO Date Treatment Began _____/_____/_____

DR COMMENTS

BLOOD PRESSURE /

Have you ever used or currently use tobacco products? ☐ YES ☐ NO How much? _____ How Often? _____

☐ cigarettes ☐ cigars ☐ pipe ☐ chew How long ago did you quit? _____

Do you drink alcoholic beverages? ☐ YES ☐ NO How much? _____ How often? _____

Have you had any other serious illness, hospitalization or accident? ☐ YES ☐ NO

If yes, please explain _____

WOMEN: Are you pregnant or suspect that you may be? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature _____ Date _____

(PARENT/GUARDIAN)

Doctor Signature _____ Date _____

DENTAL HISTORY

What is the reason for your visit today? _____

Previous Dentist's Name _____ Address _____

Date of Last Visit _____ Last Hygiene Visit _____ Last X-Rays _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you have any dental problems? Yes☐ No☐

If yes, please describe _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes ☐	No ☐
Sweets?	Yes ☐	No ☐
Biting or pressure?	Yes ☐	No ☐
Have you ever noticed any mouth odors or bad taste?	Yes ☐	No ☐
Do you frequently get cold sores, blisters or any lesions?	Yes ☐	No ☐
Do your gums bleed or hurt?	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 between your teeth?	Yes ☐	No ☐

Do you:

Clench or grind your teeth while awake or asleep?	Yes ☐	No ☐
Have tired jaws, especially in the morning?	Yes ☐	No ☐
Bite your lips or cheeks regularly?	Yes ☐	No ☐
Hold foreign objects with your teeth? (pencils, pins, nails, fingernails, pipe)	Yes ☐	No ☐
Mouth breather while asleep or awake?	Yes ☐	No ☐
Snore?	Yes ☐	No ☐

Have you ever 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 ☐
Frequent headaches, neckaches, or shoulder aches?	Yes ☐	No ☐
Any pain or soreness in the muscles of your face or around the ears?	Yes ☐	No ☐

Have you ever had:

Orthodontic treatment?	Yes ☐	No ☐
Oral surgery?	Yes ☐	No ☐
Teeth removed?	Yes ☐	No ☐
If so, have they been replaced?	Yes ☐	No ☐
Fixed Bridge?	Yes ☐	No ☐
Removable Partial?	Yes ☐	No ☐
Complete Denture?	Yes ☐	No ☐
Implants?	Yes ☐	No ☐
Are you happy with the replacement?	Yes ☐	No ☐
Periodontal Treatment?	Yes ☐	No ☐
Gum Surgery?	Yes ☐	No ☐
If so, when?		
By whom?		
Your teeth ground or the bite adjusted?	Yes ☐	No ☐
A serious injury to the mouth or head?	Yes ☐	No ☐

If so, please describe. Include cause. _____

Do you like the appearance of your teeth; your smile?	Yes ☐	No ☐
Do you like the color of your teeth?	Yes ☐	No ☐
Are your teeth as straight as you would like?	Yes ☐	No ☐

What would you like to change most in the appearance of your teeth? _____

Do you feel anxiety about having dental treatment?	Yes ☐	No ☐
Have you ever had an upsetting dental experience?	Yes ☐	No ☐

If yes, please describe, _____

How did you overcome your anxiety? _____

Is there anything else about having dental treatment that you would like us to know, please describe. _____

DR. COMMENTS:

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

Patient Signature _____ Date _____
(PARENT/GUARDIAN OF A MINOR)

Doctor Signature _____ Date _____