Pennington Family Dentistry

Creating generations of smiles since 1962

Dental personnel primarily treat the area in and around your mouth; your mouth is 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.

Patient Information

Date:_____

Name:_____ Nickname:_____

Address:_____ City_____State_____Zip_____

SS #_____Birthdate_____Patient's Sex: ☐ F ☐ M

Home Phone_____Work Phone_____Cell Phone_____

Email:_____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced ☐ Other

Person Responsible for Account:_____

Emergency Contact:_____Phone_____

How Did You Hear About Our Office?_____

Dental History

When was the date of your last dental exam? _____

Do you have a specific dental problem? Describe_____ ☐ Yes ☐ No

Do you like your smile? Why? _____ ☐ Yes ☐ No

Do you ever brux/grind your teeth? Discuss_____ ☐ Yes ☐ No

Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss_____ ☐ Yes ☐ No

_____

Do you have any dental implants? _____ ☐ Yes ☐ No

Do you snore or have trouble breathing when you sleep? _____ ☐ Yes ☐ No

Do you need pre-medication prior to dental procedures?_____ ☐ Yes ☐ No

Medical History

Medical doctor's name_____Phone_____

Are you currently under a doctor's care now? Why?_____

_____

List all medications, supplements, and or vitamins:

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to or have you had any reactions to the following:

☐ Local Anesthetics	☐ Penicillin or any other antibiotics	☐ Sulfa Drugs
☐ Barbiturates	☐ Sedatives	☐ Iodine
☐ Aspirin	☐ Any Metal (nickel, mercury, etc.)	☐ Latex Rubber

Other:_____

Women only:

Are you pregnant or think you may be pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking oral contraceptives?	☐ Yes	☐ No

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

Heart Attack	High Blood Pressure	Chest Pain (Angina)
Heart Murmur	Artificial Valves	Heart Problems
Pacemaker	Low Blood Pressure	Diabetes
Anemia	Seasonal Allergies	Thyroid Problems
Asthma	Emphysema	Respiratory Problems
Tuberculosis	Stomach Pain	Depression
Anxiety	Back Pain	Joint Replacement (knee, hip,etc.)
Arthritis	Joint Swelling	Hepatitis A, B, or C
Liver Disease	Epilepsy/Seizures	Chronic Headaches
Stroke	Kidney Disease	AIDS/HIV
Cancer	Chemo/Radiation Treatment	Leukemia

Other:_____

_____

Do you use tobacco? ☐ Yes ☐ No

Dental Insurance Information

Insurance Company_____Group #_____ID #_____

Subscriber Name:_____Relationship to Patient_____

Subscriber Birthdate_____Name of Employer:_____

Do you have secondary Dental Insurance? ☐ Yes ☐ No If yes please complete the following:

Insurance Company_____Group #_____ID #_____

Subscriber Name:_____Relationship to Patient_____

Subscriber Birthdate_____Name of Employer:_____

Hippa Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name: _____

Signature: _____ **Date: _____**

Financial Policy

TIMELY PAYMENT/METHOD OF PAYMENT: We at Pennington Family Dentistry, LLC are doing everything possible to hold down the cost of dental care. You can help a great deal by eliminating the need for us to bill you. Full payment is expected at the time of service unless other arrangements have been made in advance. This especially includes applicable deductibles and required co-payments for participating insurance companies. Pennington Family Dentistry, LLC accepts cash, personal checks and credit cards. Any check returned to our office as non-sufficient funds will be re-billed with a $35 penalty fee (as is charged to PFD by the bank). If two non-sufficient checks are returned to our office within a period of six months, we will no longer accept checks for services rendered. We will continue to provide services and accept credit cards or cash as payment for one year from the time of the last returned check.

DENTAL INSURANCE/ CO-PAYMENTS: Patients must present their insurance identification card(s) at EACH visit and if there are any changes to your insurance you must notify us. You insurance contract is between you and your insurance carrier. The benefits packages provided insurance vary from employer to employer. It is your responsibility you learn the benefits and restrictions of your policy, and follow the rules of your policy. We will bill the insurance companies we participate with; however, if we are not paid in a timely fashion, you will be responsible for the bill and expected to pay in full. Please note that although we participate with certain insurance plans, some charges may not be covered under those plans. Except as provided by such contract or by state law, we will hold you responsible for all charges no paid by your insurance carrier.

As per each individual insurance contract, the patient is required to pay a co-payment at the time of each visit. If a patient is unprepared to pay the co-payment, he/she may be required to reschedule the appointment. For patients not covered under any of the insurance plans in which we participate and for any office charges not covered by insurance, Pennington Family Dentistry, LLC requires payment at the time of service.

MISSED APPOINTMENTS: Missed appointments represent a cost to us, to you, and other patients who could have been seen during time set aside for you. Please call at least 24 hours in advance to make any scheduling changes necessary. If you arrive more than 15 minutes late for appointment, the appointment may have to be rescheduled. There will be a $50 fee per hour for missed appointments. This fee will not be covered by insurance and will be considered a personal balance. Excessive abuse of the scheduled appointments may result in discharge from the practice.

COLLECTIONS: As stated above, all fees are due at the time of service. Any charges remaining unpaid sixty (60) days after the date of service are considered past due, and will be subjected to a late fee. In this case, our billing office will make every effort to contact the person responsible for the delinquent balance, and arrange an equitable payment schedule. Until resolution of this outstanding balance, PFD will be unable to make any non-emergent appointments for any patient on the account. Further, if no effort is made is made to contact our office in return and there remains a balance due for over ninety (90) days, the account will be considered seriously delinquent and will be referred to a collection agency. In this situation, no further appointments will be granted and the responsible person will be asked to seek dental care elsewhere.

PATIENT PEFUNDS: Patient refunds will be issued when the following criteria have been met:

1. The patient has not been seen in our office for ninety (90) days.
2. There are no outstanding insurance claims on the patient's account.
3. There are no outstanding patient balances on the family account.

Print Name: _____

Signature: _____ **Date:** _____