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**PATIENT LAST NAME:** _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

**How did you hear about our practice?** _____

## INSURANCE INFORMATION

| **Primary Insurance** | **Secondary Insurance** |
|---|---|
| Subscriber Name _____ | Subscriber Name _____ |
| Subscriber ID _____ | Subscriber ID _____ |
| Date of Birth _____ | Date of Birth _____ |
| Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other | Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other |
| Employer Name _____ | Employer Name _____ |
| Employer Phone _____ | Employer Phone _____ |
| Insurance Company _____ | Insurance Company _____ |
| Insurance Group _____ | Insurance Group _____ |
| Insurance Phone _____ | Insurance Phone _____ |

***Please Present your insurance card to be photocopied for our records.***

## RESPONSIBLE PARTY *(If minor)*

Last Name: _____ First: _____ Initial: _____

Address _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

## EMERGENCY CONTACT

Last Name: _____ First: _____ Initial: _____

Telephone { ☐Mobile ☐Work ☐Home } _____

## AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

**ELECTRONIC COMMUNICATION:** I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment, and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time.

I attest to the accuracy of the information on this page.

Signature _____ Date _____
*(Responsible Party, if under 18)*

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Patient Name: _____

I authorize Dr. James Jones and/or Dr. Mark Redd or assistants as he may designate to perform those procedures as my be deemed necessary or advisable to maintain my dental health or the dental health of any minor or individual for which I have responsibility, including arrangements and/or administration of any sedative (including nitrous oxide, laughing gas) analgestic therapeutic and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause untoward reaction or side effects, which may include but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness and temporary or rarely permanent numbness. I understand that occasionally needles may break and may require surgical retrieval. Occasionally, drops of local anesthic may contact eyes and facial tissue and cause temporary irratation.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventitive treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary. I have been given the opportunity to ask questions.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your potential health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read the Notice of Privacy Practices before you deicde whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our privacy as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**Notice of Privacy Practices:** You have the right to read the Notice of Privacy Practices before you deicde whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our privacy as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to this office. Please understand that revocation of this Consent will *not* effect any action we took in reliance on this Consent before we received your revocation.

I, _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am, giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature _____ Date _____

*If this consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following*

Personal Representative's Name: _____

Relationship to Patient: _____

If patient gives office authorization to discuss personal information with parents/spouse please list the names of whom our office member can talk to.

_____ _____

**OFFICE USE ONLY**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify) _____

Signature _____ Date _____

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# FINANCIAL POLICY AND AGREEMENT

Thank you for chosing Capitol Dental Inc. as your dental health provider. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable as possible by offering several payment options. The following is a statement of our financial policy which we require you to read, agree to and sign prior to any treatment. We thank you for the opportunity to serve you and welcome any question you may have concerning our financial policies.

- Payment is due at the time of service
- We accept cash, check, American Express, Visa, Master Card, Discover and Care Credit
- We offer a very affordable in-house Discount Plan, details of which are available upon request
- Returned checks are subject to additional fees, up to $25
- In the event this account is turned over to an outside agency for collections, I/we agree to pay all attorney fees, with or without suit, court cost and a collection agency fee of 40% which will be added to the outstanding balance of my account
- A $50 fee will be charged to patients who miss or cancel their appointment without 24 hours notice

## INSURANCE

As a courtesy, we will assist with the processing of all insurance claims. We provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. We will strive to provide an accurate estimate; however, your insurance company and your plan benefits are ultimately determined by the carrier.

All charges incurred are your responsibilty, regardless of insurance coverage. As your dental care provider, our relationship is with you--our patient--not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contract.

The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have an annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations.

The claims we submit to insurance companies indicate that you have assigned those benefits to Capitol Dental Inc. However, if you are paid by the insurance company instead of Capitol Dental Inc., you then become responsible for the total account balance and payment would be expected immediately.

If you or your family have more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

## AGREEMENT

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided by this office for myself and my dependents is my own and/or attorney fees will be added to any overdue balance that requires collection initiatives.

I understand that in the absence of prompt payment, my personal and financial records concerning these professional services will be released to Capitol Dental Inc.'s legal representative(s) for collection. The legal representative will act as the providers "business associate" in compliance with the federal Health Insurance Portability and Accountability Act.

By signing below, I am authorizing Capitol Dental Inc. to call me or receive electronic communication at any number provided.

Patient Signature _____ Date _____

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PATIENT'S NAME:

## PRIMARY PHYSICIAN INFORMATION

PHYSICIAN: TELEPHONE:

CLINIC/FACILITY

## MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y ☐N HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS?
IF SO, FOR WHAT REASON?

☐Y ☐N USE TOBACCO IN ANY FORM? IF YES, TYPE:

☐Y ☐N DOES YOUR PHYSICIAN (DOCTOR) REQUIRE YOU TO PRE-MEDICATE PRIOR TO DENTAL PROCEDURES?

FEMALE PATIENTS: CURRENTLY NURSING? ☐Y ☐N CURRENTLY PREGNANT? ☐Y ☐N DUE DATE:

DO YOU KNOW OF ANY REASON WHY ROUTINE DENTAL PROCEDURES MIGHT POSE A RISK TO YOU, OUR STAFF, OR OTHER PATIENTS? ☐Y ☐N
IF YES, PLEASE DESCRIBE:

**ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):** ☐NONE

| | | | |
|---|---|---|---|
| ☐ACID REFLUX | ☐AUTO-IMMUNE | ☐BULIMIA | ☐PSYCHIATRIC TREATMENT |
| ☐ADHD | ☐ANOREXIA | ☐HEART ATTACK | ☐RADIATION/CHEMO |
| ☐AIDS/HIV | ☐CANCER/MALIGNANCY | ☐HEART DISEASE | ☐RESPIRATORY DISEASE |
| ☐ANEMIA | ☐CEREBRAL PALSY | ☐HEART MURMUR | ☐RHEUMATIC FEVER |
| ☐FREQUENT HEADACHES | ☐DRUG ADDICTION/ALCOHOLISM | ☐HEPATITIS | ☐SINUS PROBLEMS |
| ☐ANXIETY DISORDER | ☐CHICKEN POX | ☐HIGH BLOOD PRESSURE | ☐STROKE |
| ☐AUTISM/ASPERGER'S | ☐CONVULSIONS | ☐KIDNEY DISEASE | ☐STD |
| ☐ARTIFICIAL JOINTS | ☐DEPRESSION | ☐LIVER DISEASE | ☐THYROID CONDITION |
| ☐ARTHRITIS | ☐DIABETES | ☐LUPUS | ☐TUBERCULOSIS |
| ☐ASTHMA | ☐DIZZINESS/FAINTING | ☐MITRAL VALVE PROLAPSE | ☐ULCERS |
| ☐ARTIFICIAL HEART VALVE | ☐EPILEPSY/SEIZURES | ☐MONONUCLEOSIS | ☐FREQUENT EAR INFECTIONS |
| ☐GLAUCOMA | ☐PACEMAKER | ☐BLEEDING DISORDER | ☐MULTIPLE SCLEROSIS |
| ☐ALZHEIMERS/DEMENTIA | ☐COLD SORES/FEVER BLISTERS | ☐HEARING PROBLEMS | ☐SLEEP APNEA |
| ☐BACK/NECK PROBLEMS | ☐C-DIFF | ☐DOWNS SYNDROME | ☐OTHER - PLEASE LIST: |
| ☐FOOD ALLERGIES: | ☐BLOOD CLOTS | ☐HIGH CHOLESTEROL | |

**ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):**

| | | | | |
|---|---|---|---|---|
| ☐ASPIRIN | ☐CODEINE | ☐NITROUS OXIDE SEDATION | ☐SULFA DRUGS | ☐NONE |
| ☐ANESTHETIC - LOCAL | ☐LATEX | ☐METAL SENSITIVITY | ☐PENICILLIN/OTHER ANTIBIOTICS | |
| ☐OTHER - PLEASE LIST: | | | | |

## MEDICAL INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

| | | | |
|---|---|---|---|
| ☐ANTIBIOTICS/SULFA DRUGS | ☐ANTIHISTAMINES/ALLERGY | ☐DAILY ASPIRIN | ☐BLOOD PRESSURE MEDICATIONS |
| ☐BLOOD THINNERS | ☐CANCER/CHEMO MEDICATIONS | ☐CORTISONE/STEROIDS | ☐HEART MEDICATION/DIGITALIS |
| ☐INSULIN | ☐NITROGLYCERIN | ☐ORAL CONTRACEPTIVES | ☐TRANQUILIZERS |
| ☐OTHER DIABETIC MEDICATIONS | ☐RECREATIONAL DRUGS | ☐THYROID MEDICATIONS | ☐OTHER - PLEASE LIST: |
| ☐ORAL/IV BISPHORATES (OSTEOPOROSIS, PAGET'S DISEASE) | | | |

☐Y ☐N ARE YOU TAKING ANY PRESCRIPTION OR DAILY OVER THE COUNTER MEDICATIONS/DRUGS? *IF YES, LIST BELOW:*

| DRUG NAME | DOSAGE | REASON PRESCRIBED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

IS THERE ANYTHING IMPORTANT ABOUT YOUR MEDICAL CONDITION WE HAVE NOT ASKED? ☐Y ☐N
IF YES, PLEASE DESCRIBE:

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## PATIENT INFORMATION

PATIENT'S NAME: ..... TELEPHONE: .....

DATE OF BIRTH: .....

DATE: .....

## DENTAL HISTORY

DATE OF LAST DENTAL VISIT:

HOW OFTEN DO YOU BRUSH YOUR TEETH? FLOSS?

DO YOUR GUMS BLEED? WHEN? ☐ BRUSHING ☐ FLOSSING ☐ OTHER:

☐Y ☐N I AM UNCOMFORTABLE SHOWING MY TEETH WHEN I SMILE
☐Y ☐N I AM UNHAPPY WITH MY CROWNS OR FILLINGS.
☐Y ☐N MY GUMS OR TEETH ARE SENSITIVE
☐Y ☐N I AM CONCERNED THAT MY GUMS ARE RECEDING
☐Y ☐N I CLENCH OR GRIND MY TEETH
☐Y ☐N I HAVE QUESTIONS ABOUT THE BENEFITS OF DENTAL IMPLANTS

☐Y ☐N I AM UNHAPPY WITH THE APPEARANCE OF MY TEETH
☐Y ☐N I FEEL THAT MY TEETH COULD BE WHITER
☐Y ☐N I AM INTERESTED IN STRAIGHTENING MY TEETH
☐Y ☐N I FEEL MY TEETH ARE TOO LONG OR TOO SHORT
☐Y ☐N I AM ANXIOUS OR FEARFUL OF TREATMENT
☐Y ☐N IS THERE SOMETHING ELSE HOLDING YOU BACK FROM THE PERFECT SMILE? (EXPLAIN BELOW)

THE MOST IMPORTANT CONCERNS REGARDING MY DENTAL TREATMENT ARE:

WHAT FACTORS ARE MOST IMPORTANT FOR YOUR SATISFACTION WITH OUR OFFICE?

ANY ADDITIONAL CONCERNS/COMMENTS?

.....

IF CHILD/MINOR: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y ☐N ANY MOUTH HABITS? (THUMB SUCKING, TONGUE THRUSTING, NAIL BITING, MOUTH BREATHING, NURSING/BOTTLE HABITS, PACIFIER, ETC.)

☐Y ☐N DO YOU HELP YOUR CHILD WITH BRUSHING AND FLOSSING? IF YES, HOW OFTEN?

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I CERTIFY THAT THE ANSWERS TO THE HEALTH QUESTIONS ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE OF MEDICAL CONDITION OR MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT. I UNDERSTAND THAT THE ADMINISTRATION OF LOCAL ANESTHETIC MAY CAUSE AN UNTOWARD REACTION OR SIDE EFFECTS, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO BRUISING, HEMATOMA, CARDIAC STIMULATION, TEMPORARY OR RARELY, PERMANENT NUMBNESS, AND MUSCLE SORENESS. I UNDERSTAND THAT AS A RESULT OF DENTAL TREATMENT, INCLUDING PREVENTATIVE PROCEDURES SUCH AS CLEANING AND BASIC DENTISTRY, AS WELL AS FILLINGS OF ALL TYPES, TEETH MAY REMAIN SENSITIVE OR EVEN POSSIBLY QUITE PAINFUL BOTH DURING AND AFTER COMPLETION OF TREATMENT. GUMS AND SURROUNDING TISSUES MAY ALSO BE SENSITIVE OR PAINFUL DURING AND OR AFTER TREATMENT.

CONSENT FOR TREATMENT: I HEREBY GRANT AUTHORITY TO THE DENTIST AT CAPITAL DENTAL INC. TO ADMINISTER ANY TREATMENT OR TO ADMINISTER SUCH ANESTHETICS, ANALGESICS, SEDATIVES AND NITROUS OXIDE SEDATION, AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN MY DIAGNOSIS AND TREATMENT. I HAVE READ THE ABOVE TERMS AND CONDITIONS AND CONSENT FOR TREATMENT AND FULLY AGREE TO THEIR CONTENT. I DO VOLUNTARILY ASSUME ANY AND ALL POSSIBLE RISKS, INCLUDING THE RISK OF SUBSTANTIAL AND SERIOUS HARM, IF ANY, WHICH MAY BE ASSOCIATED WITH GENERAL PREVENTATIVE AND OPERATIVE TREATMENT PROCEDURES IN HOPES OF OBTAINING THE POTENTIAL DESIRED RESULTS, WHICH MAY OR MAY NOT BE ACHIEVED, FOR MY BENEFIT.

.....

SIGNATURE OF PATIENT OR GUARDIAN DATE RELATIONSHIP TO PATIENT

.....

REVIEWED BY DATE