DENTAL

Welcome Packet

Date	Patient Name	Social Security Number	
Home Address	City, State, Zip	Cell Phone	
Email Address		Work Phone	
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	☐ **MALE** ☐ **FEMALE**	Birthdate	Drivers License and State

Primary Insurance Company _____ Group_____Subscriber_____

Seconday Insurance Company_____Group_____Subscriber_____

Responsible Party		
Name	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Birthdate / /
Martial Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip

Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

How did you hear about our Office?
(check only one)

Who selected this office? ☐ Self ☐ Spouse ☐ Parent ☐ Employer

Where did you find the Phone Number to this Office? _____

☐Referred by a friend ☐Postcard or Letter ☐On-line (directory or advertisement) ☐Insurance Plan ☐Health Fair/Community Event
☐Other _____ ☐TV/Radio Ad ☐Newspaper/Magazine ad ☐Discount Mailer (i.e., Valpak) ☐ Drive by/Signage

If you were referred, whom may we thank for referring you? _____

CONSENT

*I will answer all health questions to the best of my knowledge. _____
(Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____

*Signature Date Relationship to Patient

Terms and Conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial rseponsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for at the time services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance comapny to pay directly to this office benefits accruing to me under my policy.
I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.
I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above the conditions and agree to their content.

Signed _____ **Date** _____

There may be a charge for any missed appointments or appointments not cancelled 24 hours befote the appointment time.

PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist_____ Last Visit _____ **Date of last cleaning** _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ☐ Yes! ☐ No If yes please, tell us why: _____

How often do you brush? _____ Do you floss? ☐ Yes ☐ No **How often?** _____

(Please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I would like to improve my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straighter.
Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: appearance, dental health, financial considerations, etc.)

I consider my health to be (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PATIENT'S MEDICAL HISTORY

Do you have or have you had any of the follow? Please circle Y for yes or N for no.

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Pacemaker
7. Y N Stent
8. Y N Abnormal Blood Pressure
9. Y N Anemia
10. Y N Prolonged Bleeding Disorder
11. Y N Tuberculosis or Lung Disease
12. Y N Asthma
13. Y N Hay Fever
14. Y N Sinus Trouble
15. Y N Epilepsy/Seizures
16. Y N Ulcers
17. Y N Implants/Artificial Joints: Hip-Knee_____ Other _____
18. Y N I smoke or use chewing tobacco If yes, how much per day? _____ How many years?_____
19. Y N I have consumed alcohol within the last 24 hours.
20. Y N I usually take antibiotic prior to dental treatment
21. Y N Have you ever taken Fen-Phen or Redux?
22. Y N Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition?
23. Y N I have had major surgery Year _____ Type of operation_____ Year _____ Type of operation _____
24. Y N Do you have any other medical problem or medical history NOT listed on ths form? _____

25. Y N Liver Disease
26. Y N Jaundice
27. Y N Hepatitis Type _____
28. Y N Diabetes
29. Y N Excessive Urination and/or Thirst
30. Y N Infectious Mononucleosis ("Mono")
31. Y N Herpes
32. Y N Arthritis
33. Y N Sexually Transmitted/Venereal Diseases
34. Y N Kidney Disease
35. Y N Tumor or Malignancy
36. Y N Cancer/Chemotherapy
37. Y N Radiation/Therapy
38. Y N History of Drug Addiction

39. Y N HIV
40. Y N AIDS
41. Y N Immune Suppressed Disorder
42. Y N Hearing Loss
43. Y N Fainting Spells
44. Y N Glaucoma
45. Y N History of Emotional or Nervous Disorders

WOMEN:

46. Y N Are you taking birth control medication?
47. Y N Are you or could you be pregnant or nursing?

Doctor Notes Only:

Are you allergic to any of the following?
Please circle y for Yes or N for no

48. Y N Aspirin
49. Y N Ibuprofen
50. Y N Sulfa Drugs/Sulfites/Sulfides
51. Y N Penicillin
52. Y N Codeine
53. Y N Latex, Metals, Plastics
54. Y N Local Anesthetics (i.e., Novocain, Lidocaine)
55. Y N Other Medications Which ones?

Please list all medications you are currently taking:

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Physician's Name _____ Phone _____
Address _____ Fax _____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

Initial medical/dental reviewed by:

X _____ / _____/_____
Doctor's Signature *Date*

Periodic medical/dental health reviewed by:

X _____ / _____/_____
Doctor's Signature *Date*

X _____ / _____/_____
Doctor's Signature *Date*

X _____ / _____/_____
Doctor's Signature *Date*

X _____ / _____/_____
Patient's Signature *Date*

X _____ / _____/_____
Patient's Signature *Date*

X _____ / _____/_____
Patient's Signature *Date*

X _____ / _____/_____
If patient is a minor, Guardian's Signature Required *Date*

OPĒS HEALTH TERMS AND CONDITIONS OF SERVICE

In consideration of all services provided by OPĒS HEALTH and its employees, contractors and/or affiliates(OPĒS HEALTH), the undersigned hereby acknowledges and agrees (on behalf of himself or herself and his or her children, dependents and other persons for whom he or she serves as guarantor (collectively, “dependents”)) with the following terms and conditions of service:

Medical Information. The undersigned hereby certifies that all information provided to OPĒS HEALTH is true, correct and complete and agrees to promptly inform OPĒS HEALTH of any changes in any information (including regarding any dependent). OPĒS HEALTH is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information/medical records relating to the undersigned or any dependent to obtain payment for services, determine insurance benefits or otherwise as required by law. OPĒS HEALTH is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any dependent).

Treatment; Informed Consent. The undersigned authorizes OPĒS HEALTH and any treating dentist, hygienist and/or staff to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself/herself or any dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by OPĒS HEALTH or any dentist or any other person employed or contracted by OPĒS HEALTH regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures and continuing care and failure to do so will adversely affect the patient’s treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show within 15 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a broken appointment fee. OPĒS HEALTH does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist’s supervision) and agrees to hold OPĒS HEALTH and its officers, directors, owners and affiliates harmless from any claim, suit, loss or damage related to any dental treatment. Fees in treatment plans for non-insurance/discount plan patients are only valid for 30 days; all insurance/ discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.

Financial Responsibility; Insurance. THE UNDERSIGNED PATIENT AND/OR GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF OPĒS HEALTH, WHETHER OR NOT COVERED BY INSURANCE. THE PATIENT’S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED (for treatment involving multiple appointments, such as a crown, root canal, denture or implant, the entire patient portion is normally due when treatment is started). Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started. OPĒS HEALTH submits insurance claims solely to primary dental insurance for patients’ convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed. The undersigned agrees to promptly pay on demand any balance not paid by insurance within 60 days after the date of service. Insurance balances are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by OPĒS HEALTH relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. OPĒS HEALTH reserves the right to terminate or deny any treatment if the patient’s account is delinquent.

Assignment of Benefits; Authorization and Release. The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to OPĒS HEALTH all insurance benefits covering the undersigned or any dependent for all services rendered. The undersigned hereby agrees that his/her signature below will be maintained “on file”; OPĒS HEALTH is authorized to use such signature on all applicable insuranceclaims and submissions. If any insurance payment is made to the undersigned, he/she shall immediately remit such payment to OPĒS HEALTH.

Notice of Privacy Practices. The undersigned has reviewed a copy of OPĒS HEALTH Notice of Privacy Practices effective August 01, 2016, as amended.

I have read the above terms and conditions of service by OPĒS HEALTH and understand and accept such terms:

Signature of Patient	Date	Witness
Signature of Responsible Party/Guarantor (For minors, parent or legal guardian must sign)	Date	Relationship to Patient