

Botkins Family Dental

Patient Information

Date: _____ Social Security#: _____
 Patient Last Name: _____
 Patient First Name: _____
 Address: _____
 City: _____ State: _____
 Zip Code: _____ Sex: Male Female
 Birthday Date: _____ Age: _____
 Married Single Divorced Minor Other
 Email: _____
 Employer/School: _____
 Occupation: _____
 Employer/School Address: _____

 Employer/School Phone: _____
 Spouse's Name: _____
 Birthday: _____ SS#: _____
 Spouse's Employer: _____
 Whom may we thank for referring you? _____

Insurance Information

Who is responsible for this account? _____
 Insurance Company: _____
 Subscribers' Name: _____
 Group Number: _____ SS#: _____
 Date of Birth: _____
 Is patient covered by additional insurance? Yes No
 Insurance Company: _____
 Subscribers' Name: _____
 Group Number: _____ SS#: _____
 Date of Birth: _____

Assignment and Release

I certify that I and/or my dependent(s), have insurance coverage with the company listed herein, and I assign directly to Northwest Dental Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Botkins Family Dental may use my health care information and may disclose such information to my insurance companies named herein and their agents for the purpose of obtaining payment for the services and determining insurance benefits or the benefits payable for related services.

 Please Print Name

 Please Sign Name

 Date

 Relationship to Patient

Phone Numbers: Home/Cell Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____
Emergency Contact: Name: _____ Relationship: _____
 Phone: _____ - _____ - _____ When's the best time to reach you? _____

Dental History: Reason for today's visit: _____ Former Dentist: _____
 Date of last dental visit: _____ Date of last dental X-rays: _____

Bad Breathe <input type="radio"/> Yes <input type="radio"/> No	Jaw Pain <input type="radio"/> Yes <input type="radio"/> No	Sensitivity to sweets <input type="radio"/> Yes <input type="radio"/> No
Bleeding Gums <input type="radio"/> Yes <input type="radio"/> No	Lip/cheek biting <input type="radio"/> Yes <input type="radio"/> No	Sensitivity to biting <input type="radio"/> Yes <input type="radio"/> No
Blisters on lips or mouth <input type="radio"/> Yes <input type="radio"/> No	Loose teeth <input type="radio"/> Yes <input type="radio"/> No	Smoking Cigarette/Pipe <input type="radio"/> Yes <input type="radio"/> No
Burning sensation on tongue <input type="radio"/> Yes <input type="radio"/> No	Mouth Breathing <input type="radio"/> Yes <input type="radio"/> No	Sores in your mouth <input type="radio"/> Yes <input type="radio"/> No
Chew on one side <input type="radio"/> Yes <input type="radio"/> No	Mouth Pain <input type="radio"/> Yes <input type="radio"/> No	How often do you floss? _____
Clicking or popping jaw <input type="radio"/> Yes <input type="radio"/> No	Ortho Treatment /Braces <input type="radio"/> Yes <input type="radio"/> No	How often do you brush? _____
Dry mouth <input type="radio"/> Yes <input type="radio"/> No	Pain around Ear <input type="radio"/> Yes <input type="radio"/> No	
Fingernail biting <input type="radio"/> Yes <input type="radio"/> No	Periodontal/Gum Treatment <input type="radio"/> Yes <input type="radio"/> No	
Food collection b/t teeth <input type="radio"/> Yes <input type="radio"/> No	Sensitivity to cold <input type="radio"/> Yes <input type="radio"/> No	
Grinding teeth <input type="radio"/> Yes <input type="radio"/> No	Sensitivity to heat <input type="radio"/> Yes <input type="radio"/> No	

Botkins Family Dental

Health History

Family Physician's Name: _____ Date of last visit: _____

Have you ever used a bisphosphonate medication? Yes No

(Common brand names are Fosamax, Actonel, Atelvia, Didronel or Boniva)

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Please mark "X" if you have any of the following conditions:

AIDS/HIV	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Fainting	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Shortness Of Breath	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valves	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joints	<input type="radio"/> Yes <input type="radio"/> No	Heart Problems	<input type="radio"/> Yes <input type="radio"/> No	Skin Rash	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis Type	<input type="radio"/> Yes <input type="radio"/> No	Special Diet	<input type="radio"/> Yes <input type="radio"/> No
Autism	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Back Problems	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swollen Feet/Ankles	<input type="radio"/> Yes <input type="radio"/> No
Bleeding abnormally	<input type="radio"/> Yes <input type="radio"/> No	Jaundice	<input type="radio"/> Yes <input type="radio"/> No	Swollen Neck Glands	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Jaw Pain	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Problems	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	Liver Pain	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Tumor or Growth	<input type="radio"/> Yes <input type="radio"/> No
Circulatory Problems	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Ulcer	<input type="radio"/> Yes <input type="radio"/> No
Congenital Health Lesions	<input type="radio"/> Yes <input type="radio"/> No	Alzheimer's/Dementia	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Cortisone Treatments	<input type="radio"/> Yes <input type="radio"/> No	Nervous Problems	<input type="radio"/> Yes <input type="radio"/> No	Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Cough, persistent/bloody	<input type="radio"/> Yes <input type="radio"/> No	Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Are you pregnant?	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care/Mental Illness	<input type="radio"/> Yes <input type="radio"/> No	Taking birth control pills?	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatment	<input type="radio"/> Yes <input type="radio"/> No	Are you nursing?	<input type="radio"/> Yes <input type="radio"/> No

Medications

List or supply a copy of any medications you are currently taking:

Pharmacy Name:

Allergies

- Aspirin
- Barbiturates (sleeping pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other: _____

Botkins Family Dental

General Consent Form

I _____ hereby agree on this date _____
Print Patients Full Name Today's Date

to allow the doctors and staff of Botkins Family Dental to treat me for
any and all necessary dental concerns that may be present now or in the future,

including but not limited to:

periodontal treatment (gums), prophylaxis (cleaning & exam), restorative
dentistry (fillings), endodontics (root canals & pulp treatments), prosthodontics
(dentures & partials), sealants (coatings on teeth), bleaching (whitening), bonding &
veneers (cosmetic dentistry), Invisalign (clear braces), Nitrous Oxide (laughing gas),
local anesthetic (lidocaine injection), exodontia (tooth extraction), TMJ/TMD
dysfunction (jaw joint pain), radiographs (x-rays) and other general dental care.

I realize I will have the opportunity to decline treatment at any time.

I have read the statement above and hereby consent to treatment when and if
the doctors or staff inform me that it is needed, by signing this form below.

In addition, I understand that by keeping the appointment scheduled for any
procedure listed or unlisted that I am giving my consent for treatment.

Patients Signature

Today's Date

If the patient is a child or young adult under the age of 18 please sign below.

Parents Signature or Guardian

Today's Date

Botkins Family Dental

Financial Policy

Our Commitment

Botkins Family Dental is committed to the highest quality dental care possible, offering affordable services with maximum payment flexibility. Before treatment is undertaken we will consult with you so that you fully understand the need, the procedures, and the expense of your dental treatment. Together, we will implement the best plan for your dental care. In order to achieve this, we need your understanding of our payment policy.

Payment Options

Payment is due at the time services are rendered unless other arrangements have been made in advance. In all cases, payment in full is required at treatment completion. For your convenience, we offer the following options:

- **5% Cash or Check Discount**
Patients who pay their entire bill by cash or check at the time services are rendered (whether they have dental insurance or not) will receive a 5% reward. We will assist patients with dental insurance by filing their claim and we will instruct the insurance company to reimburse the patient directly.
- **VISA, Master Card, Discover or American Express**
- **Dental Insurance**
It is important to understand our relationship is with you, not your insurance company. Additionally, our fees are the same for all patients regardless of their insurance coverage. We will present a treatment plan and an estimate of expenses, if needed, after the patient examination. Estimates are based upon available insurance information and do not guarantee payment by your insurance company. We will bill your insurance company as a courtesy; however, co-payments and deductibles are due at the time of service. Patients with dual insurance should know that they are not guaranteed 100% coverage. Fees not covered by insurance are the patient's responsibility.
- **Care credit Financing Option**
Care credit is a nationally recognized credit provider that specializes in assisting individuals with financing for their dental care. Care credit provides patients with interest free payment plans as well as extended payment plans for patients who prefer more time to pay. Patients may be approved for Care credit within a couple of minutes at our office. More information about using Care credit may be obtained from the Botkins Family Dental staff. In all cases, approval for Care credit should be arranged prior to treatment

Senior Reward

We are pleased to extend a 5% discount to our senior patients (62 years and older) regardless of payment method. Please note that this cannot be combined with the cash discount.

New Patient Emergency Appointments

We request payment at the time of service for new patient emergency procedures. We will accept cash, personal checks and money orders for new patient emergency appointments.

Broken Appointment Policy

We anticipate that all patients will keep their scheduled appointments and we will make a reasonable effort to help them do so. However, situations do arise which may cause a patient to reschedule. We will gladly reschedule appointments, but we require 24 hours advance notice. Patients who fail to attend their appointments and have not provided us with 24 hours advance notice will be charged a \$50 broken appointment fee. In addition, patients who arrive late for their scheduled appointment time may have to forfeit their appointment and may be subject to the broken appointment fee.

Acceptance of Terms

I have read and fully understand the above financial policies and agree to the terms outlined herein.

Date

(Signature of Patient or Guardian)

Signature of Patient

Botkins Family Dental

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association. **This material is for general reference purposes only and does not constitute legal advice. It covers only HIPAA, not other federal or state law. Changes in applicable laws or regulations may require revision. Dentists should contact qualified legal counsel for legal advice, including advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.**

Botkins Family Dental

Agreement to received electronic communications

Patient Name: _____

Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

[419-222-4342].

Email Address (PLEASE PRINT CLEARLY):

_____ @ _____ . _____

Patient Signature: _____

Date: _____