



New Patient Information and Health History

Name _____ Preferred Name _____ DOB _____
Address _____ Email: _____
Telephone (home): _____ (work): _____ (cell) _____

Patient Medical History

Primary Care Physician _____ Date of Last Visit _____

Previous Dentist's Name _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dental care you will be receiving. Thank you for answering the following questions.

Have you ever had any of the following? Please check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis/jaundice |
| <input type="checkbox"/> Fainting/seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach troubles |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy/convulsions | <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Kidney diseases | <input type="checkbox"/> Emphysema | <input type="checkbox"/> AIDS or HIV infection |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Leukemia | |

Please circle all that apply:

Are you under medical care at this time?	Yes	No	Reason: _____
Have you ever been hospitalized for any surgical operation or serious illness?	Yes	No	List _____
Are you taking any medications, non-prescriptions or herbs?	Yes	No	List _____
Do you use nicotine?	Yes	No	How much per day? _____ Type? _____
Do you use alcohol?	Yes	No	How often? _____
Do you use cocaine or any other drugs?	Yes	No	
Have you ever used prescription or non-prescription diet pills(Fen-Pen, Redux)?	Yes	No	
Have you been told you snore?	Yes	No	
Have you been told you have sleep apnea or told you stop breathing when you sleep?	Yes	No	
Do you have allergies?	Yes	No	List _____
Are you pregnant at this time?	Yes	No	

Patient Signature _____



New Patient Dental Questionnaire

1. Are you having a dental problem at this time? _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. How often do you floss your teeth? _____
5. Do your gums bleed while brushing? *Yes / No*
6. Do your gums bleed while flossing? *Yes / No*
7. Are your teeth sensitive to hot, cold, sweet or sour foods? *Yes / No*
8. Are your teeth sensitive to liquids? *Yes / No*
9. Have you noticed any loosening of your teeth? *Yes / No*
10. Have you experienced any of the following problems with your jaw? (check all that apply):
 - ☐ Clicking
 - ☐ Pain (joint, ear, side of face)
 - ☐ Difficulty opening or closing
 - ☐ Difficulty in chewing
11. Have you had any head, neck or jaw injuries? *Yes / No*
12. Do you have frequent headaches? *Yes / No*
13. Do you clench or grind your teeth awake or asleep? *Yes / No*
14. Have you ever had (check all that apply)?
 - ☐ Implants
 - ☐ Orthodontic treatment (braces)?
 - ☐ Oral surgery?
 - ☐ Gum treatment?
 - ☐ Endodontics? (root canal therapy)
 - ☐ Cosmetic dentistry?
15. Are you satisfied with the appearance of your teeth? *Yes / No*
16. If you could improve your smile, what would you have done? _____
17. Do you regularly receive fluoride treatment? *Yes / No*
18. Is there anything about you having dental treatment that bothers you? *Yes / No*
If yes, please explain _____
19. Whom may we thank for referring you to our office? _____
20. Have you ever had local anesthetic (numbing) used in previous dental care? *Yes / No*
21. Do you prefer it to be used? *Yes / No*

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Name (Print) _____ Date _____

Patient's Signature _____



Patient Payment Arrangements

Date _____

Name _____ Birthdate _____ SSN _____

Spouse _____ Birthdate _____ SSN _____

Address _____ City _____ ZIP _____

Telephone (home): _____ (work): _____ (cell): _____

Patient Occupation/Position _____ Employer Name _____

Employer Address _____ City _____ ZIP _____

Spouse Occupation/Position _____ Employer Name _____

Employer Address _____ City _____ ZIP _____

Please note: PAYMENT IS COLLECTED AT THE TIME OF SERVICE. High Point Dentistry will bill to your insurance and provide you the best estimate of the patient portion of treatment cost. If the estimate is more than actual, a refund or credit to your account will be issued. If the estimate is less than actual, you will be billed for the difference.

Please select one of the following and indicate payment method:

☐ **I do not have dental insurance**

High Point Dentistry requires payment at the time of service to reduce fees and bookkeeping costs.

Circle payment method: Cash Check Credit Card

☐ **I have dental insurance**

For treatment to continue, High Point Dentistry requires payment at the time of service for all deductibles and percentages not covered by your insurance carrier

Circle payment method: Cash Check Credit Card

For patients with dental insurance, please provide:

Dental Insurance Carrier _____ Subscriber # _____ Group # _____
Address _____

If patient's account becomes delinquent for a period of 30 days I, the undersigned, acknowledge that I will be responsible for any outstanding balance, interest(1.5% per month), and any collection fees.

Patient Signature _____ Date _____

Responsible Party _____

IMPORTANT NOTICE

We regret to inform you that if you neglect to sign, you will be responsible for submitting your own claims to your insurance company. We will also require payment in full at the time of your service. If you have any questions, you may speak with our Finance Department.

Due to the discrepancy between some insurance payments and dentist's fees, we are asking our patients to read the following statement:

In some cases, your dentist's fee is not covered in full by your insurance company. We want our patients to be aware of the fact that under any circumstances, patient is personally responsible for any balance due after the insurance payment. This balance due includes provisions set by your insurance company such as

- *co-payments*
- *co-insurance*
- *deductibles and*
- *"usual and customary" allowances.*

*The insurance policy held by you or your employer is a contract between the policy holder and the insurance company. **Dentists do not accept insurance companies as patients – YOU are the patient.***

This statement has been provided in hope of ensuring good communication and understanding between the dentist and the patient. If you have any questions regarding our fees, please feel free to contact our Finance Department at (262)373-1850. If you are not familiar with your insurance coverage, we ask that you discuss your policy with your employer or insurance company **before** charges are incurred.

I, the undersigned, have read and fully understand the above statement. My signature authorizes release of medical information to my insurance company as well as assignment of benefits to High Point Dentistry.

Witness (Initials)

Signature: _____

Date: _____

HIPAA CONSENT FORM

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement and authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for this healthcare facility. A copy of this document shall be as effective as the original.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

**MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION RELEASE DOCUMENT
SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER DOCTORS/FACILITIES**

Patient Name

Patient or Guardian Signature

Date



Social Media Release Form

I, the undersigned, do hereby grant permission to High Point Dentistry to post my story, photo, or other item, hereinafter referred to as "Materials," I submit to and for the Website, Twitter account, Instagram account, and Facebook account, or any social media vehicle High Point Dentistry is involved with.

I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said "Materials", including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights.

I acknowledge and agree that no sums whatsoever will be due to me as a result of the use and/or exploitation of the "Materials" or any rights therein.

Patient Name (Print)

Date

Patient Signature

Date

Witness (Employee Name - Print)

Date



Appointment Policy

Appointments are scheduled so that each patient will receive the right amount of time to be seen by our dental team and staff. That is why it is important that you keep your scheduled appointment with us, and that you arrive on time.

- To help patients remember their scheduled appointments, High Point Dentistry sends text messages and email reminders 5 days, 2 days, and 3 hours in advance of the appointment time.
- If your schedule changes and you cannot keep your appointment, please contact us as soon as possible so we may reschedule you, and accommodate those patients who are waiting for an appointment.
- As a courtesy to our office as well as to those patients who are waiting to schedule with the dental team, please give us at least 24 hours notice. **If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a \$50 “no-show” or late cancel service charge to your credit card on file.** This charge is not reimbursable by your insurance company. You will be billed directly for it.
- After three consecutive no-shows or late cancels for your appointment, our practice may decide to terminate its relationship with you.

I understand the Missed Appointment Policy of High Point Dentistry and agree to provide my credit card number, which may be charged \$50 for any no-show of a scheduled appointment. I understand I will be asked to keep a credit card on file. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show or late cancel charge.

Patient Name (printed)

Patient Signature

Date