HIGH POINT DENTISTRY
The Art of Family Dental Care

# New Patient Information and Health History

Name _____ Preferred Name_____Birthdate _____

Address _____ Email: _____

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

## Patient Medical History

Primary Care Physician _____ Date of Last Visit _____

Previous Dentist's Name _____ Date of Laser Visit_____

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.

**Has your child ever had any of the following? Please check all that apply:**

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

**Please circle all that apply:**

| | | | |
|---|---|---|---|
| Is child under medical care at this time? | Yes | No | List _____ |
| Has child ever been hospitalized for any surgical operation or serious illness? | Yes | No | List _____ |
| ***Is child taking any medications, non-prescriptions or herbs?*** | Yes | No | List _____ |
| ***Does child have any allergies?*** | Yes | No | List _____ |

Parent (or Guardian) Signature _____Date_____

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# Pediatric New Patient Dental Questionnaire

Is this your child's first dental office experience? ◯Yes ◯No

If your child has previously seen a dentist, when was the last visit? _____

Has your child ever had an upsetting experience at the dental office? ◯Yes ◯No

Is your child currently experiencing any DENTAL PAIN? ◯Yes ◯No

If yes, please describe: _____

How often does your child brush their teeth? _____

How often does your child floss their teeth? _____

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**Supplemental Questions for an Infant/Toddler**

Does your child do any of the following?

- ◯ Bottle use
- ◯ Nursing
- ◯ Pacifier Use
- ◯ Thumb/Finger Sucking
- ◯ Tongue Thrusting
- ◯ NONE

Does your child go to bed with a bottle or no-spill (sippy) cup? ◯Yes ◯No

Does your child use a no-spill (sippy) cup throughout the day? ◯Yes ◯No

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Is your child receiving orthodontic treatment? ◯Yes ◯No

Name of Orthodontist: _____

What type of water do you use?

- ◯ Municipal Tap Water
- ◯ Filtered Water
- ◯ Bottled Water
- ◯ Well Water

Does your child tend to breathe through their mouth during the day? ◯Yes ◯No

Does your child snore or grind their teeth? ◯Yes ◯No

Is there a family history of any of the following:

- ◯ Missing Teeth
- ◯ Extra Teeth
- ◯ Dental Decay
- ◯ Gum Disease
- ◯ Under/Over Bite
- ◯ Other: _____
- ◯ Jaw Surgery

Do you have any questions you would like answered by the dental team today?_____

_____

**Signature of parent/guardian:** _____

**Relationship to child**_____ **Date:** _____

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# Patient Payment Arrangements

Date _____

Name _____ Birthdate _____ SSN _____

Parent/Guardian_____ Birthdate _____ SSN _____

Address _____ City _____ ZIP _____

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

Parent/Guardian Occupation _____ 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.

Parent/Guardian 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)

_____

Patient Name:_____

Parent/GuardianSignature:_____

Date:_____

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# 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

Parent / Guardian Signature Date

Witness (Employee Name - Print) Date

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# 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 can 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 account.** This charge is not reimbursable by your insurance company. and will need to be paid prior to making your next appointment.
- Cancellations are not accepted via voicemail, email, or text message. You MUST speak to a member of our team to cancel or reschedule your appointment.
- After three consecutive no-shows or late cancels of your appointment, our practice may decide to terminate its relastionship with you.

_____

*Patient Name (printed)*

_____ _____

*Parent / Guardian 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 INFORMATON**

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