New Patient Information and Health History

Name: ______________________________ Preferred Name: ________________________________Date of Birth:__________________

Address: ____

Email: ____ Phone: ___________________________________

Patient Medical History

Primary Care Physician ____ Date of Last Visit ___________________

Previous Dentist's Name ____Date of Last 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.

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

☐Acid Reflux
☐AIDS or HIV Infection
☐Anemia
☐Angina
☐Arthritis
☐Asthma
☐Cancer
☐Cardiac Pacemaker
☐Dental Anxiety
☐Depression/Anxiety
☐Diabetes
☐Emphysema
☐Epilepsy/Convulsions
☐Fainting/Seizures
☐Glaucoma
☐Headaches/Migraines
☐Hearing Impaired
☐Heart Attack
☐Heart Murmur
☐Hepatitis/Jaundice
☐High Blood Pressure
☐High Cholesterol
☐Joint Replacement
☐Kidney Diseases
☐Leukemia
☐Liver Disease
☐Low Blood Pressure
☐Osteoporosis
☐Radiation Therapy
☐Respiratory Problems
☐Rheumatic Fever
☐Sleep Apnea
☐STDs
☐Stomach Troubles
☐Stroke
☐Thyroid Problems
☐Tuberculosis
☐Other

Are you under any non-routine medical care at this time? Yes No List ____

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 ____

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Do you use nicotine/tobacco? Yes No If yes, how much per day? ______________________________

Do you use cocaine or any other drugs? Have you ever used prescription or non-prescription diet pills (Fen-Pen, Redux)? Yes No If yes, please list________________________________

Have you been told you snore and/or stop breathing during sleep? Yes No

Do you wear any of the following (retainer, sleep appliance, dental night guard)? Yes No List ____________________________________

Do you have allergies? Yes No List ____

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Women only: Are you pregnant at this time? Yes No

Patient Signature ____ Date ____________________________________

New Patient Dental Questionnaire

1. Are you having a dental problem at this time? ____
2. How often do you brush your teeth? ____
3. How often do you floss your teeth? ____
4. Do your gums bleed while brushing? ☐Yes ☐No
5. Do your gums bleed while flossing? ☐Yes ☐No
6. Are your teeth sensitive to hot, cold, sweet or sour foods? ☐Yes ☐No
7. Are your teeth sensitive to liquids? ☐Yes ☐No
8. Have you noticed any loosening of your teeth? ☐Yes ☐No
9. Do you experience bad breath? ☐Yes ☐No
10. Have you noticed any of the following problems with your jaw? (check all that apply):

☐Clicking ☐ Difficulty in chewing ☐Difficulty in opening jaw ☐ Pain (joint, ear, side of face)

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)?

☐Cosmetic dentistry ☐ Endodontics? ☐Gum treatment? ☐ Implants? ☐Oral surgery? ☐Orthodontic treatment (braces)? ☐Sleep/Airway health screening?

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. Have you ever had an upsetting experience in the dental office? ☐Yes ☐No
18. Is there anything about you having dental treatment that bothers you? ☐Yes ☐No If yes, please explain:

____

20. Whom may we thank for referring you to our office? ____

Sleep & Airway Health Screening

1. Hours of sleep per night: ☐<5 ☐5-6 ☐7-8 ☐>8
2. Do you snore? Have you been told you snore? ☐Yes ☐No ☐Unsure
3. Pauses/gasping during sleep? ☐Yes ☐No ☐Unsure
4. Do you often feel tired, fatigued, or sleepy during daytime? ☐Yes ☐No
5. Do you experience any of the following symptoms? : ☐Dry mouth ☐Fatigue ☐Irritability ☐Morning headaches ☐Night urination
6. Have you ever been diagnosed with Sleep Apnea? ☐Yes – If yes, please list date: ___________________ ☐No
7. Are you currently using CPAP (or any other apnea/snoring device)? ☐Yes – If yes, please list:______________________☐No
8. Are you currently taking any sleeping aids (prescribed or OTC)? ☐Yes – If yes, please list: ______________________ ☐No
9. Are you aware of clenching or grinding your teeth? ☐Yes ☐No ☐Unsure
10. Mouth breathing? ☐ Yes ☐ No ☐ Unsure
11. Nasal congestion or allergies? ☐ Yes ☐ No
12. Do you have a history of any of the following? : ☐ Enlarged tonsils ☐ Tongue-tie ☐ ADHD ☐Teeth grinding

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

Patient's Name (Print) ____ Date ____________

Patient's signature ____

HIGH POINT DENTISTRY
The Art of Family Dental Care

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 (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 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

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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.

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Patient Name (printed)

____ __________________

Patient Signature *Date*