

# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## Patient Information

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
*Last Name First Name Initial*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Email \_\_\_\_\_

## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
*Last Name First Name Initial*

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Address \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

## Additional Insurance

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Address \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Please complete both sides.

## Dental History

What would you like us to do today? \_\_\_\_\_ Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Check (✓) yes or no if you have had problems with any of the following:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath              | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth  | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums           | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth    | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold   | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot    | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_ Do you wish your teeth were straighter?  Y  N

Do you wish your teeth were whiter?  Y  N Are you unhappy with any fillings, crowns or bridges?  Y  N

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

Other information about your dental health or previous treatment \_\_\_\_\_

## Medical History

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate dates \_\_\_\_\_

Have you ever taken Fen-Phen/Redux?  Y  N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva.  Y  N

Do you smoke or use other tobacco/smokeless products?  Y  N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other \_\_\_\_\_

Women: Are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Check (✓) yes or no whether you have had any of the following:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent            | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain   | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis             | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood               | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction                      | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                     | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease                                      | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism   | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                     | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting                     | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse                              | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints       | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies               | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems                                   | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                  | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                     | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery                            | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)  | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches                    | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care                                   | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur                 | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss                          | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems               | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment                                | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                  | Describe _____   | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease                                | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency     | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever                            | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy            | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes                       |  | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                    |  |  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments    | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure          |  |  |

Are you currently taking any medications? If yes, list all:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any drug allergies? If yes, list all:

\_\_\_\_\_  
\_\_\_\_\_

## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Payment is due in full at time of treatment, unless prior arrangements have been approved.



**KNOLLWOOD  
DENTAL  
GROUP, P.C.**

## Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, OR VISA/MASTERCARD/AMERICAN EXPRESS/DISCOVER.**
- **WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.**

### *Regarding Insurance*

We may accept assignment of insurance benefits, provided we are able to confirm coverage. However, we do require that the appropriate % not covered by your insurance be paid at time of service. The Balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extended plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your credit card or the extended payment plan. All accounts that have a 60-day balance will receive an automatic service charge of 18%.

### *Regarding Insurance Plans where we are a participating provider*

All co-pays and deductibles are due prior to treatment. In the event your insurance coverage changes a plan where we are not participating providers, refer to above paragraph.

### *Usual and Customary Rates*

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

### *Minor Patients*

The adult accompanying a minor and the parents (or guardians of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard/American Express/Discover, or payment by cash or check at time of service has been verified.

### *Missed Appointments*

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

### *Arbitration*

We reserve the right to submit to arbitration any dispute which might arise with regard to our services.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, and understand and agree to, this Financial Policy.

x

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date



**KNOLLWOOD  
DENTAL  
GROUP, P.C.**

## **Broken Appointment Policy**

Due to a high volume of broken appointments, there will be a charge of \$50.00 for every cleaning appointment cancelled without a 24 hour notice. The charge for treatment appointments cancelled without a 24 hour notice will be up to Dr. Brown's discretion, depending on the length of appointment. The notice must be on a business day and **CANNOT** be left on the answering machine night before or weekend of the appointment, no exceptions! We are sorry for any inconvenience; So please let us know if you will be unable to make your appointments in advance!

Signature \_\_\_\_\_

Date \_\_\_\_\_

**KNOLLWOOD DENTAL GROUP**  
**ACKNOWLEDGEMENT OF RECEIPT OF**  
**NOTICE OF PRIVACY PRACTICES**

\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT\*

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

\_\_\_\_\_  
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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_