

# SKYLINE DENTAL, LLC

## PATIENT INFORMATION

Name \_\_\_\_\_ Prefer to go by: \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City, State & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell or Message Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

How long at present address? \_\_\_\_\_ Previous Address \_\_\_\_\_

Marital Status (please check box): Single [ ] , Married [ ] , Widowed [ ] , Divorced [ ] , Other [ ]

Have other members of your family been to our office? Yes [ ] , No [ ]

Referred to our office by: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Name of Responsible Party (guardian) \_\_\_\_\_ Social Security # \_\_\_\_\_

(For billing purposes ... not necessary if paying in full at time of service)

Address (if different than patient) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ City, State & Zip \_\_\_\_\_  
Employer / Work Phone \_\_\_\_\_

How would you like to pay for your portion of the provided services? Cash [ ] , Check [ ] , Credit Card [ ] , Other [ ]

## RESPONSIBLE PARTY'S SPOUSE

Name of Responsible Party (guardian) \_\_\_\_\_ Social Security # \_\_\_\_\_

(For billing purposes ... not necessary if paying in full at time of service)

Address (if different than patient) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ City, State & Zip \_\_\_\_\_  
Employer / Work Phone \_\_\_\_\_

## DENTAL INSURANCE

Insurance Company \_\_\_\_\_ Insured Name \_\_\_\_\_

Insured DOB \_\_\_\_\_ Subscriber Number \_\_\_\_\_

Group # \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City, State & Zip

Insurance Co. Phone # \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Insurance Company \_\_\_\_\_ Insured Name \_\_\_\_\_

Insured DOB \_\_\_\_\_ Subscriber Number \_\_\_\_\_

Group # \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City, State & Zip

Insurance Co. Phone # \_\_\_\_\_

**MEDICAL HISTORY**

Please keep us updated on any future changes to your medications, allergies or medical history.

General Health: Good [ ] , Fair [ ] , Poor [ ]

Physician's Name \_\_\_\_\_ Last Complete Physical \_\_\_\_\_

Are you currently on any medications? Yes [ ] No [ ]

If 'Yes', please list medications and purpose:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to any medications? Yes [ ] No [ ]

If 'Yes', please circle or list:

Penicillin    Codeine    Latex    Local Anesthetics \_\_\_\_\_

Please mark the 'Yes' or 'No' boxes which apply to you and your Medical History:

YES	NO	Medical History	YES	NO	Medical History
		Need antibiotic coverage prior to dental work			Excessive thirst and/or urination
		Artificial joint replacement			Subject to fainting
		Undergone radiation or IV Chemotherapy			Recently hospitalized or past major surgeries
		Use or have used tobacco products in the past			(WOMEN) Currently pregnant? How far?
		Subject to prolonged bleeding			(WOMEN) Currently nursing?

Please mark the 'Yes' or 'No' boxes, if you are currently, or have ever been diagnosed or treated for:

YES	NO	Medical History	YES	NO	Medical History	YES	NO	Medical History
		Heart Disease			Ulcers / Colitis			Osteoporosis or other Bony Disease
		Heart Murmur			Acid Reflux			Thyroid Disease
		Congenital Heart Defects			Epilepsy or Seizures			Hives or Skin Rash
		Rheumatic Fever			Anemia			Glaucoma
		Abnormal Blood Pressure			Hemophilia			Long-Term Steroid Treatment
		Stroke			Jaundice or Hepatitis (Type: )			Autoimmune Disorders
		Cancer (Type: )			Kidney Disease or Dialysis			AIDS / HIV
		Tuberculosis or Lung Disease			Asthma or Hay Fever			Drug or Substance Addiction
		Shortness of Breath			Sinus Problems			Eating Disorders (Current or Past)
		Diabetes (Type: )			Chronic or Persistent Cough			Neck or Back Problems

YES	NO	Other
		Do you have any other medical or health condition which is not listed? _____
		Is there anything that you prefer to talk to the Doctor in private about?

Notes & Updates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

( For Office Use Only )

Updated: \_\_\_\_\_ Pt. \_\_\_\_\_ Staff \_\_\_\_\_

Updated: \_\_\_\_\_ Pt. \_\_\_\_\_ Staff \_\_\_\_\_

Updated: \_\_\_\_\_ Pt. \_\_\_\_\_ Staff \_\_\_\_\_

**EMERGENCY CONTACT**

Name of Relative or Person NOT LIVING with you \_\_\_\_\_ Relationship \_\_\_\_\_

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

**DENTAL HISTORY**

Reason for today's visit? \_\_\_\_\_

Last Dental Visit \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Have you ever had a serious problem associated with a previous dental treatment? [ ] Yes [ ] No  
If 'Yes', please explain \_\_\_\_\_

What dental aids do you use? [ ] Floss, [ ] Water Pick, [ ] Toothpick, [ ] Electric / Sonicare Toothbrush, [ ] Perio Aid, [ ] Other

Are you familiar with the term 'Preventive Dentistry'? . . . . . [ ] Yes [ ] No

When used properly, do you believe in the dental benefits of Fluoride? . . . . . [ ] Yes [ ] No

Do you plan on maintaining your teeth for the rest of your life? . . . . . [ ] Yes [ ] No

**Please check any of the following which apply to you:**

- [ ] Gums bleed during brushing or flossing
- [ ] Gums feel tender or swollen
- [ ] Pain with brushing or flossing
- [ ] Frequent sensitivity to cold, hot or sweets
- [ ] Usually break fillings or teeth
- [ ] Pain with biting or chewing
- [ ] Jaws frequently feel tired or sore
- [ ] Regularly clench or grind your teeth
- [ ] Bad odors or tastes in mouth
- [ ] Currently (or previously) used a mouthguard or splint
- [ ] Frequent cold sores, blisters or other oral / lip lesions
- [ ] Food frequently gets caught between teeth
- [ ] Previous (or current) Periodontal (gum) surgery
- [ ] Previous (or current) Orthodontics (braces)
- [ ] Previous (or current) injury or trauma to your teeth, mouth or face
- [ ] Previous (or current) biopsy of the mouth, lips or face
- [ ] Either took fluoride as a child, or grew up in a fluoridated community
- [ ] Currently using a Tartar Control, Whitening or Baking Soda Toothpaste

**CONSENT FOR TREATMENT** (Please sign unless you have any questions)

I hereby authorize this Dental Practice to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

**Insurance Release:** I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

**Responsibility for Payment:** In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection of sums due and unpaid for the work herein set forth.

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

**MINORS OR CHILDREN**

Because (name of child) \_\_\_\_\_ is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

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

# SKYLINE DENTAL, LLC

## OFFICE POLICIES

Please review and sign at the bottom, acknowledging that you were informed of these policies.

### FINANCIAL POLICY

In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good dental health and we wish to spend our time and energy toward that end.

To assist our patients, we offer the following methods for taking care of their account at our office:

- We offer a 5% discount, when you pay by cash or check on the day of service.
- We accept credit cards (Visa, Mastercard & Discover), but no discount will be given as we pay a credit card user fee.
- As a courtesy, we will gladly bill your insurance when you provide us with the current information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you either pay your portion of the bill at the time of service, or that a suitable written financial agreement be reached at the time of service. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. You are ultimately responsible for payment of your account.
- For patients who qualify, we offer various payment plans through a third party Financing Company. There are numerous payment options that will fit comfortably in almost any monthly budget. These companies offer a revolving line of credit that can be used by the whole family for ongoing treatment without having to reapply. There are no upfront costs, pre-payment penalties or annual fees to our patients.
- We may offer a very simple payment plan to patients of record who have demonstrated a one to two year history of good credit at our office. We do charge interest (1.5% per month) similar to a credit card, on all accounts which we are asked to carry. The maximum amount of credit we may offer you is six (6) times the amount of your chosen monthly payment. For example, if you choose to make monthly payments of \$100, we would offer you and your family treatment up to \$600. We would need to halt treatment on a temporary basis, when you come near or exceed the credit-limit that you had set for yourself. On major restorative or cosmetic work such as crowns, veneers, bridges, implants or dentures; you would be asked to pay half the cost of the treatment at the time of service.

### FAILED OR CANCELLED APPOINTMENTS

We kindly ask that patients give us 24-hour notice, if they are unable to keep an appointment. There will be a \$25 *minimum* charge for failed appointments. The length of time reserved and the number of prior failed appointments determines your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice. You may leave a message on our after-hours message phone, if you find out that you are unable to honor an appointment after our office has closed for the day.

### ESTIMATES AND FEES

After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. Except in extreme emergencies, financial arrangements are made before treatment is rendered. There is a service charge on all unpaid accounts.

### DELINQUENT ACCOUNTS

Delinquent accounts which have to be turned over to a Credit Reporting Collection Agency will have their balances increased 50% to cover the expenses associated with the Collection Agency. In addition to these collection agency expenses, delinquent accounts are also liable for Attorney fees and court costs associated with the collection of the debt.

### NOTICE OF PRIVACY PRACTICES (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office and attached to the New Patient paperwork which you are being asked to complete in our office. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices.

Please let us know if you have any questions or concerns about any of our Office Policies; otherwise please sign below:

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_