DENTAL HISTORY Patient Name: _____

Who may we thank for referring you to our practice? _____

Do your gums bleed while brushing or flossing? Yes No

Are your teeth sensitive to hot or cold liquids/foods? Yes No

Are your teeth sensitive to sweet or sour liquids/foods? Yes No

Do you feel pain in any of your teeth? Yes No

Do you have any sores or lumps in or near your mouth? Yes No

Have you had any head, neck or jaw injuries? Yes No

Have you ever experienced any of the following problems in your jaw?

a) Clicking
b) Pain (joint, ear and side of face)
c) Difficulty in opening or closing
d) Difficulty in chewing?

.

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Have you ever had any difficult extractions in the past? Yes No

Have you had any orthodontic work? Yes No

Have you ever had prolonged bleeding following extractions? Yes No

Have you ever had instruction on the correct method of brushing your teeth? Yes No

Have you ever had instructions on the care of your gums? Yes No

Are you satisfied with your teeth's appearance? Yes No

Do you have any dental problems now? Yes No

If yes, please describe:_____

Date of last visit and what was done: _____

_____

Would you like to change anything about your smile? _____

How frequently do you brush, floss, or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe_____

Authorization, Release, & Agreement to Pay for Services Rendered

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

CASH □ PERSONAL CHECK □ CREDIT CARD □ VISA□ MASTER CARD □ CARD # _____ EXP _____

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Office Policies for Barbara A. Pintz, R.D.H., D.D.S.

Dear Patients,

We have established the following policies to enable us to focus on our primary goal: providing you with the highest quality dental care.

1. For your convenience, we will submit a claim to your primary insurance carrier for each date of service. We will accept assignment of benefits on claims submitted to your primary insurance carrier. Benefits on secondary claims will be assigned to the policy holder.
2. All co-pays, deductibles, and fees for non-covered procedures must be paid for at the time of service. If you do not know your co-pay, you may use our phone to find out. You are responsible for verifying that we are an in-network provider under your plan.
3. We will make initial contact with your insurance company if they have not responded within a reasonable time frame; however it is your responsibility to know your benefits and follow up with your insurance company regarding payment. You may call your insurance company at any time to verify your benefits, ask a question regarding what is covered or check the status of a claim.
4. There are many different insurance plans among carriers. Not all services or procedures may be covered under your specific plan; however, Dr. Pintz will provide all care necessary to your dental health. The patient accepts financial responsibility for non-covered services.
5. Accounts with balances over 30 days will be charged a re-billing charge of $5.00 for each billing cycle and a monthly finance charge of 5%.
6. Accounts with balances over 90 days and without an established current payment plan will be sent to a collection agency regardless of the circumstances. All collection fees will be added to the amount to be collected.
7. If your account is sent to collections, you and any family members will be discharged from the practice.
8. If you are unable to keep an appointment, please notify our office 48 hours in advance. Missed appointments or appointments cancelled with less than 48 hours notice will be billed a missed appointment fee. Missed appointment fees range between $50-$100 depending on the day, time, and length of the appointment.

I have read and understand the above policy. I value Dr. Pintz's services, and I understand that I must do my part to ensure payment of her professional care.

Patient Name: _____

_____

Signature of Patient or Parent/Guardian Date

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients,) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Name: _____

_____
Signature of Patient, Parent or Guardian

Date: _____

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Cell Phone: _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Name	
Date	
Age	
Sex	

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE SITUATIONS DESCRIBED BELOW, IN CONTRAST TO FEELING JUST TIRED? THIS REFERS TO YOUR USUAL WAY OF LIFE IN RECENT TIMES. EVEN IF YOU HAVEN'T DONE SOME OF THESE THINGS RECENTLY, TRY TO WORK OUT HOW THEY WOULD HAVE AFFECTED YOU.	Would never doze	0
	Slight chance of dozing	1
	Moderate chance of dozing	2
	High Chance of Dozing	3
Sitting and reading		
Watching TV		
Sitting inactive in a public place (e.g. a theater or a meeting)		
As a passenger in a car for an hour without a break		
Lying down to rest in the afternoon when circumstances permit		
Sitting and talking to someone		
Sitting quietly after a lunch without alcohol		
In a car while stopped for a few minutes in traffic.		
Total		

How long does it take you to fall asleep?	
Hours of sleep per night?	
Awaken how many times per night?	
Fall back asleep in how many minutes?	
Awaken rested ? Yes or No	