



Name: \_\_\_\_\_  
Last First MI Title

Preferred Name: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Domestic Partner

How did you hear about our office? \_\_\_\_\_

Do you prefer to be contacted for appointment confirmation via e-mail or phone? \_\_\_\_\_ (Please circle preference)

### ■ Insurance – Primary ■

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

### ■ Insurance – Secondary ■

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

### ■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Havens Family Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT:** I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: \_\_\_\_\_



Do you have a personal physician?  Yes  No Date of last visit: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Do you use tobacco in any form?  Yes  No

Have you had any metal rods, pins or implants placed?  Yes  No

Are you taking any medications?  Yes  No

Please list each one: \_\_\_\_\_

Have you ever had any surgical procedures?  Yes  No

Please list each one: \_\_\_\_\_

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Conditions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Conditions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<b>Yes</b>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Facial Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<b>Yes</b>
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<b>If Female, Please Answer</b>

Nearest relative **not living with you:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

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

How may we help you today? \_\_\_\_\_

Your current dental health is:  Good  Fair  Poor

Do you require antibiotics before dental treatment?  Yes  No

Are you currently in pain?  Yes  No

Have you ever had gum treatment?  Yes  No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ)  Yes  No

Are you under stress? (new job, moving, relationships)  Yes  No

Do you snore?  Yes  No

Are you tired even after a full night of sleep?  Yes  No

Is there anything you would like to change about your smile?  Yes  No

Would you like to change the color of your teeth?  Yes  No

Do your gums bleed?  Yes  No

Are your teeth sensitive to heat, cold or anything else?  Yes  No

Have you lost any teeth?  Yes  No

Have you ever had a serious/difficult problem with any previous dental work?  Yes  No

Have you ever had any unfavorable dental experiences?  Yes  No

How many times a do you: floss/week? \_\_\_\_\_ brush/day? \_\_\_\_\_

When was your last dental cleaning? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

How can we accommodate you better during your dental visit? \_\_\_\_\_

Here at Havens Family Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Zoom Tooth Whitening

Veneers/Lumineers

Invisalign

Nitrous Oxide Sedation

Root Canal Therapy

Smile Makeover

Crown and Bridge

Implants

Sleep Apnea Therapy

Partials/Dentures

Night/Sport Guards

White Fillings



PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
  - Obtaining payment from third party payers (e.g. my insurance company);
    - The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

Print Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Havens Family Dental
1582 N Waggoner Road
Blacklick, Ohio 43004

# Havens Family Dental Insurance and Financial Policy

At **Havens Family Dental**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

## Initial

\_\_\_\_\_ ■ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

\_\_\_\_\_ ■ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

\_\_\_\_\_ ■ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, **Havens Family Dental** reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

\_\_\_\_\_ ■ **Havens Family Dental** does require payment in full **for your portion** at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). **In order to reserve appointments, Havens Family Dental requires a deposit of 25% of your copay at the time of scheduling.** If you are in need of an extended finance option, we also work with Care Credit, who offers, 6 and 12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

\_\_\_\_\_ ■ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **\$50/hour cancellation fee** (emergencies are an exception).

\_\_\_\_\_ ■ In the event of an emergency after regular business hours a **\$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **\$125 after hour's emergency fee**.

**I agree with the above conditions.**

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_