Date: _____

Patient Information:

Name_____ D.O.B._____ SS#_____

Address_____ Apt_____

Town_____ State_____ Zip_____ Marital Status_____

Home Phone_____Cell#_____ Other_____

Email_____

Employer_____ Work Phone_____

EMERGENCY CONTACT: Name_____Phone_____

Responsible Party: (if different from above)
Name_____ Address_____
SS#_____ Birth date_____

Whom May we thank for this referral? (current patient, Yellow Pages, 1800 Dentist, etc)
_____

Dental Insurance Information: check if does not apply ____

Name of person carrying insurance_____

Insurance Company Name_____

Insurance ID # **or** social security #_____

Insured's D.O.B_____

Group Number_____

Insured employer name_____

Do you have another dental insurance?_____

Dental History:

How can we help you today?_____

Former Dentist's Name:_____ Date of last dental visit?___ _____

How often do you brush?_____ How often do you floss?_____

PLEASE CHECK ALL THAT APPLY:

Y or N	Bad Breath	Y or N	Food Collects between teeth	Y or N	Pain around ear
Y or N	Bleeding Gums	Y or N	Foreign Objects	Y or N	Periodontal Treatment
Y or N	Blisters on lips/mouth	Y or N	Grinding teeth	Y or N	Sensitivity to cold
Y or N	Burning on Tongue	Y or N	Gums swollen or tender	Y or N	Sensitivity to hot
Y or N	Chew on one side of mouth	Y or N	Jaw pain or tiredness	Y or N	Sensitivity to sweets
Y or N	Cigarette or cigar smoking	Y or N	Lip or cheek biting	Y or N	Sensitivity when biting
Y or N	Clicking or popping jaw	Y or N	Loose teeth/broken fillings	Y or N	Sores in mouth
Y or N	Dry mouth	Y or N	Mouth breathing	Y or N	Orthodontic Treatment
Y or N	Fingernail biting	Y or N	Mouth pain		

UNIQUE DENTAL CARE

Please answer the following questions:

1. Have you ever taken pre-medication (antibiotics) before dental visits? Y or N
2. Have you had any periodontal treatment (gum treatment) in the past? Y or N
3. Do you have sensitivity to hot, cold, sweets or when chewing? Y or N
4. Do you take Aspirin (Bayer, Bufferin) on a regular basis? Y or N
5. Have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel)? Y or N
6. Have you ever been diagnosed with a problem with either jaw joint? Y or N
7. Does your jaw click, pop, or make noise when you open and close? Y or N
8. Is there pain or tenderness in your jaw joint when you open, close or chew? Y or N
9. Has your jaw ever locked open or closed? Y or N
10. Do you have frequent headaches? If so how often? _____ Y or N
11. Do you clench or grind your teeth, or ever been told you do? Y or N
12. Have you ever had trauma to your chin or jaw? Y or N

Medical History:

Physician's Name_____ Date last visit? (approx) _____

Additional Specialist doctors:_____ Date of last visit?_____

Please circle Y (yes) or N (no) for ALL medical conditions listed below:

Y or N	Aids/HIV	Y or N	Jaundice	Y or N	Blood Disease
Y or N	Cortisone Treatments	Y or N	Sinus Trouble	Y or N	Glaucoma
Y or N	Heart Problems	Y or N	Artificial pins, joints	Y or N	Mitral Valve Prolapse
Y or N	Respiratory Disease	Y or N	Diabetes	Y or N	Thyroid Problems
Y or N	Anemia	Y or N	Kidney Disease	Y or N	Cancer
Y or N	Circulatory Problems	Y or N	Stroke	Y or N	Headaches
Y or N	Hepatitis (type____)	Y or N	Asthma	Y or N	Pacemaker
Y or N	Rheumatic Fever	Y or N	Epilepsy	Y or N	Tumors or growths
Y or N	Arthritis	Y or N	Liver Disease	Y or N	Chemical Dependency
Y or N	Congenital Heart Lesions	Y or N	Skin Rash	Y or N	Heart Murmur
Y or N	High Blood Pressure	Y or N	Abnormal Bleeding	Y or N	Radiation treatment
Y or N	Scarlet Fever	Y or N	Fainting/dizziness	Y or N	Ulcers
Y or N	Artificial Heart Valves	Y or N	Low Blood Pressure	Y or N	Venereal Disease
Y or N	Persistent cough	Y or N	Swollen neck glands	Y or N	Weight Loss, unexplained

Women: Are you Pregnant ____ Nursing ____ Taking Birth Control Pills? _____

Have you ever taken any group of drugs that are affiliated with Fen-phen? Yes or No

Please List **ALL** medications you are taking, the amount and frequency for each: _____

_____ _____

_____ _____

_____ _____

Allergies: Do you have any allergy to any of the following OR medication? Please circle any that apply

Latex	Aspirin	Barbituates (sleeping pills)
Penicillin	Codeine	Iodine
Sulfa	Local Anesthetic	Other_____

SIGNATURES: Please sign below:

PATIENT or guardian _____/____/____ DOCTOR/R.D.H_____ ___/___/___

Office Policies

FINANCIAL AGREEMENT: ***Payment is due at time of service***

Financial assistance is available, upon credit approval.

As a courtesy to you, we will submit all charges to the insurance company. Insurance is designated to cover a portion of the customary fee. Co-payments are collected at time of visit. (Please see our insurance policies.)

BALANCES LEFT ON ACCOUNT FOR OVER 90 DAYS: All parties will be responsible for the cost of collection, which may include but is not limited to any and all collection and legal fees.

Returned checks: There will be a $25.00 fee. **Patient Initials_____**

CANCELLATION AND FAILURE TO ARRIVE:

We understand that circumstances do arise that can keep you from a dental appointment. Please, have the courtesy to give the office 72 hours notice. Please understand that we have reserved the doctors time for you and we will try to contact you at all phone numbers listed to confirm your appointment.

There will be a $75.00 charge for all appointments missed or cancelled without 72 hours notice

Patient Initials_____

X-RAYS: Original x-rays are the property of Unique Dental Care. If you wish to have your x-rays duplicated, there will be a $25.00 charge. A notice of 72 hours is required prior to picking up or mailing out. Emailing a copy will be at no charge.

Patient Initials_____

PRIVACY NOTICE:

Privacy Act: I give Unique Dental Care permission to send reminder postcards to me through U.S. Postal Service, and to leave messages via answering machine, voicemail, e-mail, cell phone, or other family members.

By signing below, I understand the above listed policies, and assume responsibility for all services rendered.

Patient Signature_____ Date _____

Attention Insured Patient,

In order to submit claims accurately, the following are needed:

1. **We need all necessary information on the policy holder**.

2. **Information does need to be verified by the insurance company.**

Note:

Information provided by the insurance company **IS NOT A GUARANTEE OF BENEFITS**, only *an **estimation***. Please review your policy book so there are no misunderstandings. If you do not have a policy book, contact your human resource office.

You, the patient, are responsible for your own policy, we are third party billing only, and given minimal information by your insurance company.

You are responsible for all co-pays at time of service, and any balance that may occur after the insurance has paid. We do send dental pretreatment estimates to your insurance if treatment is diagnosed and discussed. This is done to have approval on file if treatment is rendered. It is NOT submitted for reimbursement until actual services are performed.

OUR GOAL:

To give you the best estimate possible with the information given to us by your insurance company**.**
Until the insurance company receives the actual CLAIM, it remains an ESTIMATE and not a GUARANTEE.
TREATMENT PLANS AVAILABLE.

By signing below,

I authorize direct payment of the insurance benefits to Unique Dental Care and its' associate doctors, for treatment rendered to me and/or my child/children.

I have read and understand the above policies.

Patient Signature_____ **Date** _____

Broken Appointment Policy

We here at Unique Dental Care work hard to meet and exceed the expectations of all our patients. As always, we are dedicated to providing you with the best care and services possible.

Your appointment time is specifically reserved for you on our schedule. We emphasize the importance of keeping all scheduled appointments with reminder emails, post cards, and phone calls.

When sufficient notice is not given to cancel, reschedule or miss a confirmed scheduled appointment, it does not give us enough time to contact another patient who could be looking for the same time that we reserved for you.

So that the dentist, our staff, and our patients will not be penalized by those who fail to keep scheduled appointments, **we are enforcing our office policy by charging a $75.00 fee for failure to not give the office at least 48 hours notice.**

Patient Signature_____ Date _____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept know risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read the items below and sign at the bottom of the form.

1. **Treatment to be provided**

   I understand that during my course of treatment that the following care may be provided: Examinations, Diagnostic and Preventive Services, Restorations, Crowns, Bridges

   Patient Initials_____

2. **Drugs Medications**

   I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues: pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Patient Initials_____**

3. **Changes in Treatment Plan**

   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist top make any/all changes and additions as necessary. **Patient Initials_____**

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. **Patient Initials_____**

Patient Signature_____ Date _____

ACKNOWLEDGEMENT OF HIPAA AND PRIVACY PRACTICES

****You may refuse to sign this Acknowledgement****

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

_____
Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. Acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)