Welcome

Date: _____

Patient Information:

Name: _____ Date of Birth: _____ Male: ___ Female: ___

SSN #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Preferred #: Home / Work / Cell Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Contact Phone: _____ Relationship to patient: _____

Whom may we thank for referring you to our office? _____

Responsible Party:

Name: _____ Date of Birth: _____ Male: ___ Female: ___

SSN #: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Preferred #: Home / Work / Cell Home: _____ Work: _____ Cell: _____

Insurance Information:

Primary Insurance: _____ Phone: _____

Insurance address: : _____ City: _____ State: _____ Zip: _____

Employee: _____ SSN#: _____ Date of Birth: _____

Realtionship to patient: _____ Employer: _____ Group #: _____

Primary Insurance: _____ Phone: _____

Insurance address: : _____ City: _____ State: _____ Zip: _____

Employee: _____ SSN#: _____ Date of Birth: _____

Realtionship to patient: _____ Employer: _____ Group #: _____

Baldwin Distictive Dentistry Financial and Appointment Policy

` Thank you for choosing our office for your dental needs. We realize that every person's financial situatuion is different. For this reason, we have worked hard to provide a variety of payment options to heal you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budge. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

If you have insurance, as a courtesy we will file insurance claims for you. The estimated portion not covered by your insurance carrier is due at the time of service. Please realize insurance is estimated. Once insurance has paid any remaining balance must be paid by the patient. Insurance companies frequently reimburse at lower rate than we estmiate. When this occurs, you may be required to pay an additional "after Insurance" balance. YOU ARE ULTIMATELY RESPONSIBLE FOR KNOWING YOUR INSUANCE BENEFITS.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Optional Payment Terms:

1. **Full Pay Cash Discount:** We offer a 5% accounting courtesty for all treatment that is paid in full (cash or check) at the time of service.
2. **Major Service – Two Payment Option:** We offer a two-payment option for crowns, bridges, and denture treatment. We ask that you pay one-half of your estimated co-pay at the first appointment and the second half at the seat date appointment.
3. **Credit Card Payment Option:** We allow (with a signed agreement form and **established payment history with our office of at least a year**), a Credit Card Payment Option, which allows you to make three equal installments by credit card. One-third payment is due at the first appointment, one-third is due thirty days later, and the remaining one-third is due in sixty days from the initial appointment. Our office personnel will charge these payments to your credit card on the due dates.
4. **Term Loan:** By arrangement with Care Credit or Lending Club, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for details.

Payments are expected at the time of service are rendered. We accept cash, checks (under $500.00), debit cards, and all major credit cards.

Broken appointments:

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 a 24 hour notice prior to cancelling or changing your appointment to avoid a $50.00 hour fee** (emergencies are an exception).

"I also acknowledge and agree that in the event I do not pay for services rendered, Distinctive Dentistry may place my account with a collection agency. Per NRS 649.375(2)(b), a collection fee of 50% will be added to the balance in the event the terms are not met and resonable attorney fees and court cost incurred in collection of my over due account.

I authorize payment of dental benefits to Baldwin Distinctive Dentistry. I authorize disclosure of my health information for this processing of dental claims.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Dental Health Questionnaire

What are some things we can do to make your dental visits as comfortable as possible?

_____

_____

Appearance:

If you could change your smile would you:

- Make it Brighter/Whiter?---------- Yes No
- Make it Straighter?---------- Yes No
- Close Spaces?---------- Yes No
- Repair Chipped Teeth?---------- Yes No
- Replace Missing Teeth?---------- Yes No
- Have a Smile Makeover?---------- Yes No
- Replace Black Mercury Fillings?---------- Yes No
- Replace Old Crowns that don't match?---------- Yes No

Dentures:

Do you wear partial or full dentures?---------- Yes No

Would you be interested in replacing your loose dentures with fixed teeth or having your existing dentures relined?---------- Yes No

Any concerns/questions for us?

_____

_____

We look forward to providing you with a comfortable and professional dental appointment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACE PRACTICES

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

_____

Please print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknoledgement could not be obtained because:

____ Indvidual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation pervented us from obtaining acknowledgement

____ Other (Please Specify)

_____

_____

Patient Name: _____ Date of Birth: _____ Date: _____

Medical Physician's Name: _____

Have you been hospitalized recently? Yes or No

Please list: _____

Are you currently taking any over the counter or prescription medications? Yes or No

Please list: _____

Do you have any ALLERGIES to medication or substances? Yes or No

Please list: _____

Do you require antibiotic coverage for dental procedure? Yes or No

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Indicate which of the following you have had or have at present. Please circle Yes or No to each item:

Anemia Yes No	Emphysema Yes No	Mitral Valve Prolapse Yes No
Asthma Yes No	Epilepsy or Seizures Yes No	Multiple Sclerosis Yes No
Arthritis Yes No	Fainting or Dizziness Yes No	Nervousness/Anxiety Yes No
Artificial Heart Valve Yes No	Fever Blister or Herpes Yes No	Osteoporosis/Medication Yes No
Artificial Joints (Hips, etc.) Yes No	Glaucoma Yes No	Psychiatric Treatment Yes No
Autoimmune Disease Yes No	Hay Fever Yes No	Radiation Therapy Yes No
Bleeding Disorder Yes No	Heart (Disease, Surgery) Yes No	Rheumatic Fever Yes No
Blood Transfusions Yes No	Heart Murmur Yes No	Sinus Problems Yes No
Cancer Yes No	Heart Pacemaker Yes No	Stroke Yes No
Chemotherapy Yes No	Hepatitis (A, B, or C) Yes No	Thyroid Condition Yes No
Congenital Heart Condition Yes No	High/Low Blood Pressure Yes No	Tuberculosis Yes No
Current Tobacco Use Yes No	HIV or Aid Yes No	Weight Changes Yes No
Diabetes Yes No	Kidney Problems Yes No	Ulcers/ Colitis/ G.E.R.D.S. Yes No
Drug Addition/Alcoholism Yes No	Liver Disease Yes No	

Do you have or have had any disease or condition not listed? Yes or No

If yes, please list: _____

Blood Pressure Reading: *Office to fill out*

_____ _____/_____

Have you ever had an adverse reaction to dental anesthetic or topical gels? Yes or No

How often to you brush? _____ Floss? _____ Do you use other dental aids? _____

Are your gums or teeth sensitive Yes or No

Do your gums bleed? Yes or No

Do you have pain in your jaw joint? Yes or No

Do you clench or grind your teeth? Yes or No

Do you wear a bite guard when sleeping Yes or No

FOR WOMEN ONLY:

Are you Pregnant Yes or No

Are you Nursing Yes or No

Taking Birth Control Yes or No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency. I will notify the dentist of any health or medical changes. I authorize radiographs, study models, any other diagnostic aids deemed appropriate to make a through dental diagnosis. I authorize treatment, medication and therapy that may be indicated.

Signature or Guardian Signature: _____ Date: _____