Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (Confidential)

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Office Phone _____

May We Text or E-mail Appointment Reminders? ☐ Yes ☐ No

S.S. # _____ Email Address _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____

City _____ State _____ Full Time Part Time

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ S.S. # _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

☐ Discover ☐ AMEX ☐ Care Credit

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ S.S # _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group # _____ Policy / ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Secondary Insurance

Name of Insured _____ Relationship to Patient _____

Birthdate _____ S.S # _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group # _____ Policy / ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or 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 my dependents.

X _____

Signature of patient (or parent/guardian if minor) *Date*

Next Generation DENTISTRY

Keeping Your Family Smiling for Generations

WELCOME to the FAMILY!

How happy are you with your current smile (1- not happy; 5- very happy)?

1 2 3 4 5 N/A

What would you like to change if possible?

_____

_____

What was one or more things you liked the best about your last dentist?

_____

_____

What was one or more things you did not like about your last dentist?

_____

_____

What are you expecting out of your visit for today? What would you like completed?

Next Generation Dentistry FINANCIAL POLICY

Welcome! Thank you for selecting us as your dental healthcare providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Financial Agreement: Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using Cash, Check, Visa, Mastercard, Discover, American Express. We also offer Care Credit, which is a financing option for healthcare expenses. Returned checks will be subject to a $35.00 fee.

Payment in full with Cash or Check discount: We offer a 10% accounting courtesy for all services over $500 that is paid in full prior to commencement of services.

Care Credit: By arrangements with Care Credit, we can offer patients upon approval, no interest for 6 or 12 months with no pre-payment policy. Ask for an application.

Appointments: We try to maintain an efficient appointment system. However, our cost of providing care increases when people fail to keep scheduled appointments or cancel at the last minute. Our office requires at least a 24 hour notice for any cancelled appointments. We reserve the right to dismiss you as a patient after three missed appointments.

Insurance: Dental plan benefits are determined by your employer, not your dentist. Your dental plan policy is a contract between you and your plan company. Your plan and payment is your responsibility. A plan is not a guarantee of payment, it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your Claim for you if you present your insurance card and all required information. You will be expected to pay for services rendered if this office is unable to verify your plan information before treatment. If payment for services already rendered has not been paid in full within 90 days, either by you or your plan company, the remaining balance for treatment is considered due and must be collected from you.

Please indicate your understanding and acceptance of these financial polices by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patients Name (print)_____ **Date**_____

Patients Signature_____ **Date**_____

Next Generation Dentistry

673 East Wilbeth Road

Akron, Ohio 44306

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I understand that as part of my healthcare this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implantation will mail a copy of any revised notices to the address that I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and the organization is not *required* to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon to request the following restrictions to the use or disclosure of my health information.

_____Accepted _____Denied

Signature_____

Patient name_____ Date_____