Patient Information

Name_____ Birth Date_____ SS#_____

Address_____ City/Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

E-mail_____ Preferred method of contact? Home Cell Work E-mail

Marital Status S M D W

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

May we contact you via text message and/or email regarding your appointments? ☐Yes ☐No ☐Only Text ☐Only Email

Acknowledgement of Notice of Privacy Practives *COPY OF HIPPA PRIVACY DISCLOSURE WILL BE PROVIDED UPON REQUEST

Print Name:_____ Signature_____ Date: ____/____/_____

Release of Information

Reich Dental Center is comitted to protecting the privacy of our patients. Therfore, we are unable to give financial and/or dental information to anyone other than the patient, guardian or referring doctor. If there is someone other than yourself that we may provide information to, please indicate below:

Name	Relationship	Information to Provide
_____	_____	☐Dental Treatment ☐Financial
_____	_____	☐Dental Treatment ☐Financial
_____	_____	☐Dental Treatment ☐Financial
_____	_____	☐Dental Treatment ☐Financial

Former Dentist Name/Phone Number_____ Date of Last Visit_____

Have you ever had major dental treatment? ☐Yes ☐No If yes, please describe_____

Do you find yourself brushing too hard? ☐Yes ☐No

Do you smoke or use smokeless tobacco products? ☐Yes ☐No If yes, please describe_____

Do you wear full/partial dentures? ☐Yes ☐No If yes, do you have any fit concerns?_____

Do you wear a retainer? ☐Yes ☐No If yes, how old is it?_____

Have you ever had any of the following?

☐Bleeding Gums
☐Loose Teeth
☐Bad Breath
☐Injury to face or jaw
☐Issues with Clenching/Grinding Teeth
☐Pain Opening Mouth
☐Other Treatment by Oral Surgeon
☐Extractions
☐Mouth Ulcers
☐Gum Surgery or Grafting
☐Sinus Problems
☐Jaw or Joint Pain
☐Fever Blisters (or Cold Sores)
☐Clicking or Popping
☐Tooth/Gum Sensitivity or Pain
☐Deep Cleaning(Scaling and root planning)
☐Pain/Sensitivity with teeth/gums
☐Reaction to Dental Anesthesia
☐Food or Floss Catching Between Teeth
☐Jaw Surgery
☐Dry Mouth
☐Other_____

If yes to any of the following, please explain_____

Cosmetics

Are you happy with the overall appearance of your teeth? ☐Yes ☐No If no, please describe_____

Are you interested in bleaching or whitening your teeth? ☐Yes ☐No

Are you interested in braces or other orthodontic treatment? ☐Yes ☐No

Would you like to discuss the cosmetic appearance of your teeth? ☐Yes ☐No If yes, please describe_____

As a courtesy to our patients, our office will file primary insurance forms. However, insurance coverage is a contract between the patient, employer and the insurance company. Our office can only estimate insurance coverage based on the information we receive from the patient, therefore, the patient is ultimately responsible. All other fees are due at the time of service.

The above information is correct to the best of my knowledge.

_____ _____

Signature of Patient/Legal Guardian Date

Medical History

Patient Name_____

Name/Number of emergency contact _____

Physicians Name/Number_____

Are you currently being treated for a medical condition? ☐Yes ☐No If yes, please describe_____

Have you been hospitalized or recently had surgery? ☐Yes ☐No If yes, please describe_____

What medications are you currently taking?_____

Have you ever been advised to take an antibiotic prior to dental work? ☐Yes ☐No If yes, please describe_____

Are you currently taking any blood thinners(Coumadin, Plavix, etc.), ? ☐Yes ☐No If yes, please describe_____

Are you allergic to or had any reactions to any of the following?

☐Codeine ☐Erythromycin ☐Penicillin or Amoxicillin
☐Local Anesthesia ☐Latex ☐Asprin or Ibuprofen ☐Other Allergies_____

Have you had any of the following?

☐Bleeding Disorder	☐Heart Attack	☐Thyroid Problem	☐Organ Transplant
☐Arthritis	☐Heart Surgery	☐Pace Maker	☐Artificial Heart Valves
☐Heart Shunts	☐Stroke	☐Epilepsy	☐Congenital Heart Disease/Defects
☐Lupus	☐Diabetes	☐Asthma	☐Lung Problems/COPD
☐Rheumatic Fever	☐Stomach Ulcers	☐Headaches	☐Mitral Valve Prolapse
☐Tuberculosis	☐Anemia	☐High Blood Pressure	☐Infective Endocarditis
☐Cancer	☐AIDS/HIV	☐Prosthetic Joints	☐Emotional or Nervous Disorders
☐Angina	☐Hepatitis	☐Low Blood Pressure	☐Radiation Therapy or Chemotherapy
☐Heart Murmur	☐Fainting	☐Back Problems	☐Kidney Problems
☐Sleep Apnea/Breathing Difficulties			☐Other_____

If you answered yes to any of the above, please explain_____

Would you consider yourself to be in good health? ☐Yes ☐No_____

Is there any other medial condition you woud like us to know about? ☐Yes ☐No_____

WOMEN: Are you currently pregnant? ☐Yes ☐No If yes, when is your due date?_____

Are you breastfeeding? ☐Yes ☐No Are you taking birth control? ☐Yes ☐No

Are you currently taking any medications for bone density(Actonel,Fosamax, Boniva, Reclast,etc.)?

☐Yes ☐No If yes, please describe_____

I hereby accept full and complete responsibility for all debts and obligations incurred during the course of the above named patient's treatment by Reich Dental Center. By signing this form I agree to pay all costs of collection including 1.5% interest per month on unpaid balances, reasonable attorney fees and court costs. By signing this form, I consent to your use and discolsure of my protected health information to carry out treatment, payment activities and healthcare operations. I also understand that it is my responsiblilty to notify the doctor of any changes in my health and/or medicaitons before any dental treatment. By signing this form, I not only agree to the above, but I am also verifying the the information above is correct to the best of my knowledge.

_____ _____ _____

Signature of Patient/Legal Guardian Print Patient Name Date

Office Policy and Financial Information

NON-INSURED PATIENTS: *Payment is due in full at the time service is provided in our office.*

PATIENTS WITH INSURANCE: *All co-payments and deductibles are due at the time of service. We will bill insurance carriers on your behalf if possible. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable from you. Our office will always strive to help you obtain the maximum possible coverage. It is, however, the patient's ultimate responsibility to determine the extent of coverage allowed by the insurance company.*

In addition, preauthorization of a procedure is not a guarantee for payment. Any procedure may be considered not covered under the terms of your agreement with your insurance company. Your insurance carrier will make a determination of payment once the claim is received. If after the claim is reviewed and it is determined by your insurance company that the procedure is not covered (or viewed as cosmetic or unnecessary), you will be financially responsible to Reich Dental Center, for the charges and will be billed for those services not covered by your insurance company.

NONCOVERED SERVICES: *Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.*

MISSED APPOINTMENTS: *In fairness to other patients and the practice, we require at least 24 hour notice to cancel an appointment. You may be charged* ***$50.00 for each appointment that was missed or not canceled with 24 hour notice****. Patients with multiple infractions will be considered for dismissal from the practice.*

Print Patient/Guardian Name: _____

Signature of Patient/Guardian: _____

Date: _____

REICH DENTAL CENTER

DR. ROBIN REICH, DR. KRISTIN COONEY, DR. LAUREN HUGHES, DR. STACEY WINGAD

Patient Name: _____

Though rare, the following complications may occur during or after dental treatment.

- Pain and swelling
- Possible bruising, bleeding
- Injury to neighboring teeth, restorations, or soft tissues
- Reversible or irreversible nerve damage
- Infection
- Adverse reactions to medications, anesthesia, or substances used for treatment
- Post procedure discomfort to hot, cold, and biting

I will follow the verbal and written postoperative instructions and return for a follow-up appointment if requested or necessary.

_____ _____

Patient or Guardian Signature Date