Date: _____ GETTING TO KNOW YOU AS OUR PATIENT

Patient Name	Social Security Number	Home Phone ( )	
Home Address	City, State, Zip	Cell Phone	
Email Address		Work Phone	
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	☐ **MALE** ☐ **FEMALE**	Birthdate	Drivers License and State

Primary Insurance Company _____ Group_____Subscriber_____

Seconday Insurance Company_____Group_____Subscriber_____

Responsible Party		
Name	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Birthdate / /
Martial Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip

Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

How did you hear about our Office?
(check only one)

Who selected this office? ☐ Self ☐ Spouse ☐ Parent ☐ Employer

Where did you find the Phone Number to this Office? _____

Referred by a friend	Postcard or Letter	On-line (directory or advertisement)	Insurance Plan	Health Fair/Community Event
Other _____	TV/Radio Ad	Newspaper/Magazine ad	Discount Mailer (i.e., Valpak)	Drive by/Signage

If you were referred, whom may we thank for referring you? _____

CONSENT

*I will answer all health questions to the best of my knowledge. _____
(Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____

*Signature Date Relationship to Patient

Terms and Conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial rseponsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for at the time services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsable for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance comapny to pay directly to This Office benefits accruing to me under my policy.
I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with repsect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.
I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above the conditions and agree to their content.

Signed _____ **Date** _____

There may be a charge for any missed appointments or appointments not cancelled 24 hours befote the appointment time.

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist_____ Last Visit _____ **Date of last cleaning** _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____
Are you nervous about seeing a dentist? □ Yes! □ No If yes please, tell us why: _____

How often do you brush? _____ Do you floss? □ Yes □ No **How often?** _____

(Please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I would like to improve my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain
Y N My gums feel tender or swollen
Y N I have problems eating .
Y N I have had orthodontics.
Y N I have had a facial or jaw injury
Y N I want my teeth straighter
Y N I want my teeth whiter

What are your dental priorities? _____
(e.g.: appearance, dental health, financial considerations, etc.)

PATIENT'S MEDICAL HISTORY

I consider my health to be (check one): □ Excellent □ Good □ Fair □ Poor

Do you have or have you had any of the follow? Please circle Y for yes or N for no.

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Pacemaker
7. Y N Stent
8. Y N Abnormal Blood Pressure
9. Y N Anemia
10. Y N Prolonged Bleeding Disorder
11. Y N Tuberculosis or Lung Disease
12. Y N Asthma
13. Y N Hay Fever
14. Y N Sinus Trouble
15. Y N Epilepsy/Seizures
16. Y N Ulcers
17. Y N Implants/Artificial Joints: Hip-Knee_____ Other _____
18. Y N I smoke or use chewing tobacco If yes, how much per day? _____ How many years?_____
19. Y N I have consumed alcohol within the last 24 hours.
20. Y N I usually take antibiotic prior to dental treatment
21. Y N Have you ever taken Fen-Phen or Redux?
22. Y N Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition?
23. Y N I have had major surgery Year _____ Type of operation_____ Year _____ Type of operation _____
24. Y N Do you have any other medical problem or medical history NOT listed on ths form? _____

25. Y N Liver Disease
26. Y N Jaundice
27. Y N Hepatitis Type _____
28. Y N Diabetes
29. Y N Excessive Urination and/or Thirst
30. Y N Infectious Mononucleosis ("Mono")
31. Y N Herpes
32. Y N Arthritis
33. Y N Sexually Transmitted/Venereal Diseases
34. Y N Kidney Disease
35. Y N Tumor or Malignancy
36. Y N Cancer/Chemotherapy
37. Y N Radiation/Therapy
38. Y N History of Drug Addiction

39. Y N HIV
40. Y N AIDS
41. Y N Immune Suppressed Disorder
42. Y N Hearing Loss
43. Y N Fainting Spells
44. Y N Glaucoma
45. Y N History of Emotional or Nervous Disorders

WOMEN:

46. Y N Are you taking birth control medication?
47. Y N Are you or could you be pregnant or nursing?

Doctor Notes Only:

Are you allergic to any of the following?
Please circle y for Yes or N for no

48. Y N Aspirin
49. Y N Ibuprofen
50. Y N Sulfa Drugs/Sulfites/Sulfides
51. Y N Penicillin
52. Y N Codeine
53. Y N Latex, Metals, Plastics
54. Y N Local Anesthetics (i.e., Novocain, Lidocaine)
55. Y N Other Medications Which ones?

Please list all medications you are currently taking:

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Physician's Name _____ Phone _____
Address _____ Fax _____

In the event of an emergency please contact:
Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

Initial medical/dental reviewed by:
X _____ / _____/_____
Doctor's Signature *Date*

Periodic medical/dental health reviewed by:

X _____ / _____/_____
Doctor's Signature *Date*

X _____ / _____/_____
Doctor's Signature *Date*

X _____ / _____/_____
Doctor's Signature *Date*

X _____ / _____/_____
Patient's Signature *Date*

X _____ / _____/_____
Patient's Signature *Date*

X _____ / _____/_____
Patient's Signature *Date*

X _____ / _____/_____
If patient is a minor, Guardian's Signature Required *Date*

GETTING TO KNOW YOU AS OUR PATIENT

Detailed Contact Information

We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of communications at any time by clicking the unsubscribe link in the footer of each email or by replying to a text message with 'STOP'. Standard Text Messaging rates apply.

Please Verify Your Contact Information

Home Phone

Work Phone

* **Cell Phone**

* **Email**

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Reflections Dental P.C. in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Reflections Dental P.C. in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

Signature Date

FINANCIAL AGREEMENT

Method of Payment

Please check one of the following:

- ☐ Payment in full at each appointment (No insurance)
- ☐ Your total estimated insurance co-payment at each appointment.
- ☐ Monthly budget payments (Care Credit Financing Available)

*__FINANCE CHARGE.__ If the account balance is not paid within 60 days of the monthly billing date a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month, which is an ANNUAL PERCENTAGE RATE OF 18% applied to the last month's balance. In the case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account.

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for all benefit, for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I understand that the information that I have given today is correct and the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office any changes to my child's medical status. I authorize the dental staff to perform any necessary dental services my child may need.

The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Authorized Signature:_____ Date:_____

(Patient Signature or Parent/Guardian Signature)

White vs. Silver Fillings

During the course of a dental examination, you may be advised of the need to place new fillings. Should this need arise, please be advised that white fillings (composites) will be used. At Reflections Dental, PC we believe that there are advantages and disadvantages to both types of fillings.

We have decided to exclusively place white fillings in our practice. Some of the reasons for this decision are: White fillings add strength to the tooth due to the bonding process; White fillings allow us to create more conservative preparations in the teeth, thereby saving tooth structure; White fillings can generally be replaced in a timelier manner, thereby preventing unnecessary loss of tooth structure due to undiagnosed recurrent tooth decay. White fillings are cosmetically more pleasing for the patient; and we have found that in our practice, white fillings create less post operative sensitivity.

If you have any questions or concerns, please feel free to ask us.

_____ _____

Signature Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

[Retain this page in Patient records]

Privacy Notice Amendment September 2013

I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use on my Personal Health Information.

_____ _____

patient or guardian signature date

_____ _____

practice witness date

Reflections Dental P.C.
18475 N. 91st Ave., Suite 1
Peoria, AZ 85382

Informed Consent to Photograph/ Video

I, _____, due hereby give my consent for Dr. Hildebrandt or staff to take and/or display photograph(s)/video of my face and teeth. The photograph will be used for educational and/or advertising purposes by Reflections Dental P.C. and may be displayed within our office and/or on the dental office's webpage, http://reflectionsdental.com. Also may be displayed on our Facebook page or Youtube Channel. Dr. Hildebrandt and staff will protect the patient's personal data, such as name, age and date of birth, from being displayed.

_____Signature

_____Witness