SERENITY DENTAL CARE
TOUCHING HEARTS WITH EVERY SMILE

Patient Information

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we are happy to help.

Personal

Name _____
Last First MI Prefferred

DOB _____ SSN# _____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Mobile # _____ Work # _____ Email _____

Preferred contact method [ ] Home [ ] Work [ ] Mobile [ ] Email [ ] Text

Preferred contact for Confirmations [ ] Home [ ] Work [ ] Mobile [ ] Email [ ] Text

Preferred contact for recall [ ] Home [ ] Work [ ] Mobile [ ] Email [ ] Text

Student Status if dependent is over 19 (for Insurance) [ ] Non Student [ ] Fulltime [ ] Parttime

How did you hear about us? [ ] Google [ ] Internet [ ] Website [ ] Insurance [ ] Referral

Referral Name _____ (We'd like to thank them)

Address & Home Phone

Please check if same for the entire family [ ]

Address _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Insurance Policy 1

Your relationship to subscriber [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID# _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Insurance Policy 1

Your relationship to subscriber [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID# _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Comments _____

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Medical History Form

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we are happy to help.

Medical History

Name _____
Last First MI

Name of Medical Doctor _____ City _____ State ____

Emergency Contact _____ Phone _____ Relationship _____

List of all medications that you are taking: (INCLUDING INJECTIONS)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you taking the medication PROLIA (Denosumab)? [ ] Yes [ ] No If yes, how often? _____

Are you allergic to any of the following? ANY OTHER ALLERGIES/FOOD/DRUG NOT MENTIONED?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Asprin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

_____
_____
_____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N			
☐	☐	Asthma	☐	☐	Heart Trouble	☐	☐	Liver Disease	☐	☐ HIV/AIDS
☐	☐	Bleeding Problems	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever		
☐	☐	Cancer	☐	☐	Joint Replacement	☐	☐	Sinus Trouble		
☐	☐	Diabetes	☐	☐	Osteoporosis	☐	☐	Stroke		
☐	☐	Heart Murmur	☐	☐	Kidney Disease	☐	☐	Ulcers		
☐	☐	DO YOU HAVE A PACE MAKER?				☐	☐	Pregnancy Trimester [ ] Due Date		

Tabacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit? _____ Are you in pain? [ ] Y [ ] N

New Patients

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? [ ] Yes [ ] No

Do you have BiteWing x-rays that are less than 1 year old? [ ] Yes [ ] No

Name of former Dentist _____ City _____ State ____

Date of last cleaning and exam? _____

Signature: _____ Date: _____

Financial Policy

Financial Policy

Please read and sign below

To All Patients:

Our practice determines fees by the level of care, skill, and judgment a procedure requires. We require payment in full for your portion at the time of service. We accept all major credit cards, cash, and checks.

If you are in need of a financial option, we work with Compass Payment Solutions who offer short term and extended term financing options designed to meet your treatment needs on approved conditions.

TO PATIENTS WITH DENTAL INSURANCE

We are happy to assist you if you have dental insurance. We do request that you carefully read your policy so you are aware of any limitations of your insurance.

We currently file various amounts of insurance plans, including individual plans. The insurance plans we currently have on file with may or may not be considered in or out of Network. It is important to review your policy for this information. While we maintain computerized histories of information by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have. It remains only an estimate.

We bill your insurance as a courtesy. If insurance does not pay within 45 days, we reserve the right to request payment in full for services from you. You will be refunded after payment has been received from insurance for all outstanding claims. This is rare, but it is important you recognize the insurance you have is a legal contract between you and your insurance company. Ultimately, you are responsible for all charges incurred in our office.

Patient Signature _____

Date _____

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HIPAA

HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:
- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day health care operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Signature _____

Date _____

Family Members we may release information to:

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____

Phone Number _____ Relationship _____

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____

Phone Number _____ Relationship _____