Welcome to our office!

Please take a moment to share with us your information…

Name: ______________________ Preferred name or nickname: ______________________

Home address/City/State/Zip Code: ______________________

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Home telephone number: ______________________ Work phone: ______________________

Cell Phone: ______________________ Email address: ______________________

Date of birth: ______________________ Social security number: ______________________

Your occupation: ______________________ Please Circle: Minor Single Married Divorced Widowed Separated

If you are a student, please list the school you are attending: ______________________

Whom may we thank for referring you to our practice? ______________________

Insurance information…

Do you have dental insurance? YES NO Primary card holder’s name: ______________________

Primary card holder’s employer: ______________________ Insurance company name: ______________________

Insurance company group number: ______________________ Insurance company phone number: ______________________

Primary card holder’s date of birth: ______________________ Primary card holder’s social: ______________________

Please list the member or subscriber ID number if one is provided: ______________________

Your relationship to the card holder: Self Spouse Child

Emergency contact information…

Whom may we notify in case of an emergency? ______________________

Best contact number: ______________________

Address: ______________________

Medical History

Please answer the following questions so that we may provide optimum care for you…

Are you currently under the care of a medical doctor? ______________________________

If so, please provide the Doctor's name and reason for care: ______________________________

Are you currently taking any prescription drugs? Please list: ______________________________

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Do you have any allergies? Please list: ______________________________

Are you pregnant or suspect you may be pregnant? ____________ Do you take birth control? ____________

Have you had any major surgeries in the last five years? ____________ Please list date: ____________

Do you have pins, plates, screws, or artificial joints? ______________________________

Do you use more than two pillows to sleep at night? ________ Do you wake up with shortness of breath? ________

Have you lost or gained more than ten pounds in the last year? ________ Are you on a special diet? ____________

Have you ever been informed of a heart murmur, condition, or had heart surgery? Please explain in detail: ________

____

Have you ever bled excessively? ________ Have you ever had complications with anesthesia? ____________

Please circle any of the following and provide a date if you have had or currently have:

AIDS:	Congenital Heart Lesions:	Hemophilia:	Psychiatric Treatment:
Anemia:	Cortisone Meds:	Hepatitis A, B or C:	Rheumatic Fever:
Angina Pectoris:	Diabetes (Type I or Type II):	High/Low Blood Pressure:	Rheumatism:
Arthritis:	Drug Addiction:	HIV:	Scarlet Fever:
Asthma:	Eating Disorder:	Hives:	Sickle Cell Disease:
Bisphosphonate Therapy:	Emphysema:	Kidney Trouble:	Sinus Trouble:
Blood Transfusion:	Epilepsy:	Liver Disease:	Stroke:
Cancer:	Fainting:	Mitrovalve Prolapse:	Thyroid Disease:
Chemotherapy:	Glaucoma (Wide or Narrow):	Narcotic Addiction:	Tuberculosis:
Chest Pain:	Hay Fever:	Nervousness:	Ulcers:
Cold Sores:	Heart Problems:	Osteoporosis:	X-Ray or Cobalt Treatment:

Is there anything that has not been covered on this form that you would like to share with us regarding your overall dental history? ______________________________

The information I have give today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my medical or dental status.

____

Patient Signature: Date: Doctor's Signature: Date:

Dental History

Please answer the following questions so that we may provide optimum care for you…

Reason for today's visit: ______________________________

How long has it been since you last dental visit? __________ Were dental x-rays taken? __________

Previous Dentist's name: __________________ Previous Dentist's phone number: __________

Was there any recommended dental treatment not completed? ______________________

Do you feel nervous about having treatment? Yes No

Have you ever had an unpleasant experience at a dental office? Yes No

Are your teeth sensitive to: Heat Cold Biting Pressure Sweets

Does your jaw pop or click? Yes No

Do you clench or grind your teeth? Yes No

Do you have frequent head, neck, or shoulder aches? Yes No

Have you ever had braces or other orthodontic treatment? Yes No

Does food constantly get stuck between your teeth? Yes No

Do you brush and floss daily? Yes No

Do your gums ever bleed when you brush or floss? Yes No

Is there ever an unpleasant taste or odor in your mouth? Yes No

Do you smoke or use tobacco? Yes No

In general, how do you feel about your overall dental health? ______________________

What do you like about your smile? ______________________________

Are you dissatisfied with the way your teeth look? If so, please explain (i.e. shape, color, and aesthetics):

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____

Is there anything that has not been covered on this form that you would like to share with us regarding your overall dental history? ______________________________

The information I have give today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my medical or dental status.

____

Patient Signature: Date: Doctor's Signature: Date:

Dental Privacy Notice - HIPAA

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 512 992-2822.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Rigby Advanced Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Rigby Advanced Dental Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Rigby Advanced Dental.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Rigby Advanced Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I ______________________________ have reviewed Rigby Advanced Dental Privacy Policy.

Signed ___________________________ Date

Office Policy & Consent Form

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:

  Your insurance is a contract between you, your employer, and the insurance company.
  We are not a party to that contract.

  We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
  Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover, American Express and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor, our staff and other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 24-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $80.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $80 cancellation fee will be assessed for the first individual and $50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm you appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date ________________ Signature_________________________________(Patient, Parent or Guardian)