

## Get Acquainted Questionnaire

In order for us to better serve you, please fill out the following information completely:

Name: \_\_\_\_\_  
(first) (middle) (last)

Address: \_\_\_\_\_  
(number & street) (city) (state) (zip code)

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Business Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you married? Yes \_\_\_ No \_\_\_ Spouse's Name: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Approximate date of last dental visit: \_\_\_\_\_

### FOR PATIENTS WITH DENTAL INSURANCE

Insurance Company: \_\_\_\_\_ Group/Plan No. \_\_\_\_\_

Insurance Company (if dual): \_\_\_\_\_ Group/Plan No. \_\_\_\_\_

If patient is a student - Name of School: \_\_\_\_\_

Dental insurance is a contract between the employer and the patient. It has no connection at all to the provider of dental treatment. Estimates implied or expressed are not a guarantee of insurance benefits or patient eligibility at the time the services are performed. We will make every effort possible to assist you with your insurance coverage. We will also provide an estimate that will show expected insurance reimbursement and patient share for every procedure. The patient share will be due at the time of treatment unless prior arrangements have been made. If the insurance payment is not received by our office within 60 days, the fee will become the sole responsibility of the patient.

I, the undersigned, have read all of the above provisions, and I consent to all the terms and conditions as set forth in this agreement.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAL HISTORY

Your current physical health is:

   Good    Fair    Poor

Are you currently under the care of a physician?

   No    Yes

Please Explain \_\_\_\_\_

Are you taking any prescription/over-the-counter drugs?    No    Yes

Please list each one \_\_\_\_\_

For Women: Are you taking any birth control pills?

   No    Yes

Are you pregnant?    No    Yes Week# \_\_\_\_\_

Are you nursing?    No    Yes

Have you ever had any of the following diseases or medical problems?

- |                              |                          |
|------------------------------|--------------------------|
| Y N Heart Attack             | Y N Psychiatric Problems |
| Y N Stroke                   | Y N Epilepsy             |
| Y N Cancer                   | Y N Seizures             |
| Y N Chemotherapy             | Y N Fainting Spells      |
| Y N Heart Murmur             | Y N Diabetes             |
| Y N Rheumatic Fever          | Y N Tuberculosis (TB)    |
| Y N HIV                      | Y N Venereal Disease     |
| Y N AIDS                     | Y N Hemophilia           |
| Y N Heart Surgery            | Y N Abnormal Bleeding    |
| Y N Pacemaker                | Y N Ulcers               |
| Y N Shingles                 | Y N Colitis              |
| Y N Mitral Valve Prolapse    | Y N Heart Defect         |
| Y N Kidney Problems          | Y N Anemia               |
| Y N Artificial Bones, Joints | Y N Radiation Treatment  |
| Y N Artificial Valves        | Y N Asthma               |
| Y N Sinus Problems           | Y N Arthritis            |
| Y N High Blood Pressure      | Y N Difficulty Breathing |
| Y N Low Blood Pressure       | Y N Hospitalized         |
| Y N Fever Blisters           | Y N Hepatitis            |
| Y N Blood Transfusion        | Y N Glaucoma             |
| Y N Migraines                | Y N Emphysema            |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

Are you allergic to any of the following drugs?

- |                  |                        |           |
|------------------|------------------------|-----------|
| Y N Penicillin   | Y N Tetracycline       | Y N Latex |
| Y N Aspirin      | Y N Codeine            | Y N Other |
| Y N Erythromycin | Y N Dental Anesthetics |           |

Please list any other drugs that you are allergic to: \_\_\_\_\_

Medical History Update/Changes

Date	Changes	Initial
_____	_____	_____
_____	_____	_____

DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain?    No    Yes

Have you ever had a serious difficult problem associated with any previous dental work?

   No    Yes

Do you now or have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD)?

   No    Yes

Your current dental health is:

   Good    Fair    Poor

Do you like your smile?    No    Yes

Do your gums ever bleed?    No    Yes

How many times a week do you floss? \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_

What type of bristle do you use?

   Hard    Medium    Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

!! Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

!! Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.

Medical History Update/Changes

Date	Changes	Initial
_____	_____	_____
_____	_____	_____

## Financial Policy

1. We will accept assignment of benefits provided the patient pays their co-payment for each visit. The patient will have to pay the yearly deductible, if it has not already been met. The patient is ultimately responsible for any unpaid balances after 60 days of filing the insurance claims.
2. Patients needing crowns, bridges or dentures must make payment in full by the time of the initial placement. Again, if it is necessary for us to accept assignment of Dental Benefits, we will place the crown, bridge or denture when the patient's portion is paid in full.
3. Our practice strives to be punctual. We ask that our patients keep their appointments and also be on time. If it is necessary to cancel an appointment, we ask that we be given 24 hours notice. **There will be a \$50 charge to the patients account for any appointments not canceled 24 hours prior to their scheduled time.**
4. A \$10 return check fee will be added to your balance for all returned checks.
5. A service charge of 1.5% will be incurred on all balances over 30 days, unless prior financial arrangements have been made.
6. A misunderstanding can be an obstacle to establishing a successful relationship. If at anytime you have a question regarding treatment, fee or service, please discuss it with us promptly and openly.

I hereby acknowledge that I have read and understood this document in its entirety.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Thank you for your cooperation and welcome to our practice.

**Release and Assignment**

Date \_\_\_\_\_

To \_\_\_\_\_  
Insurance Company

Group No. \_\_\_\_\_

Certificate No. \_\_\_\_\_

I hereby authorize **The Exchange Dental Group** and its dentists to release to your company or its representative, and information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care.

I also authorize and request your company pay directly to the above named doctor the amount due me in my pending claim for Dental treatment or services, by reason of such treatment or services rendered to:

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**Patient**

\_\_\_\_\_  
**Signature of Insured**

\_\_\_\_\_  
\_\_\_\_\_  
**Address**

## Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Other Individuals Allowed Access To My Records

Spouse \_\_\_\_\_

Mother \_\_\_\_\_

Father \_\_\_\_\_

Son/Daughter \_\_\_\_\_

Significant Other \_\_\_\_\_

Other \_\_\_\_\_

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### Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason