Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Drivers License State and #_____

Home Phone: _____ Cell: _____ Work: _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code Email Address

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Drug Allergy
- ☐ Latex Allergy
- ☐ other: _____

☐ Artificial Joints
☐ Asthma
☐ Blood Disease
What Type: _____
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths/Tumors
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy (current)
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ _____
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problem
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Joint Replacement
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Please list any medications you are currently taking: _____

_____

_____

- Are currently or have you ever taken any type of Bisphosphonates : ☐ Yes ☐ No
  (Example: Aclasta, Atelvia, Boniva, Fosamax, Reclast)
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Patient Dental History

1. Do you use tobacco? ☐ Yes ☐ No
2. Do your gums bleed while brushing/flossing? ☐ Yes ☐ No
3. Are your teeth sensitive to hot or cold foods/liquids? ☐ Yes ☐ No
4. Do you feel any pain to your teeth? ☐ Yes ☐ No
5. Do you have any sore or lumps in or near your mouth? ☐ Yes ☐ No
6. Do you have any head, neck, or jaw injuries? ☐ Yes ☐ No
7. Do you have frequent headaches? ☐ Yes ☐ No
8. Do you clench or grind your teeth? ☐ Yes ☐ No
9. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
10. Have you had any difficult extractions in the past? ☐ Yes ☐ No
11. Have you had any orthodontic work? ☐ Yes ☐ No
12. Have you ever had prolonged bleeding following extractions? ☐ Yes ☐ No
13. Have you ever experienced any of the following jaw problems ...
    - A Clicking? ☐ Yes ☐ No
    - B. Pain (joint, ear, side of face)? ☐ Yes ☐ No
    - C. Difficulty opening/closing ☐ Yes ☐ No
    - D. Difficulty chewing? ☐ Yes ☐ No

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Home Phone: _____ Cell: _____ Work: _____ Ext: _____

Address: _____
Street Apartment #

_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

OFFICE POLICIES AND FINANCIAL AGREEMENT

It is our desire to make high quality dental care affordable for everyone. The established financial policy of this office is that full payment is due at the time of service. However, we accept assignment of benefits on most major insurance policies, and also have charge plans available should you need to make extended payments on your account. The following is a statement of our Financial Policy which we require that you read, agree to and sign before any treatment. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our staff.

PAYMENT OPTIONS: We are pleased to offer extended payment plans and 12-month interest free financing. This allows our patients to make monthly payments instead of having to pay in full at the time of service. If you would like to make extended payments for services provided at our office, simply fill out an application form to establish your line of credit. There is NO CHARGE for completing the application and there is NO ANNUAL FEE.

Please mark whether you have insurance or not. Then choose one of the payment options.

_____ I DO NOT HAVE DENTAL INSURANCE.

_____ I would like to pay by cash, check or credit card at the time of service.

_____ I would like to apply for an extended payment plan through CareCredit.

_____ I HAVE DENTAL INSURANCE.

_____ I would like to pay my estimated portion by cash, check or credit card at the time of service.

_____ I would like to apply for an extended payment plan through CareCredit.

DENTAL INSURANCE: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage; however, we can make no guarantee of any estimated coverage or payment. Most dental insurance plans do not cover 100% of the cost of your treatment. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Because the insurance policy is an agreement between you and your insurance company, we ask that all patients be responsible directly for all charges. Please know that we will do everything possible to see that you receive full benefits of your policy.

RETURNED CHECKS: A $25.00 charge applies when a check is returned by the bank.

OVERDUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debts including attorney fees, court fees and any other fees associated with the collection of your debt.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

APPOINTMENTS: In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We do charge a $35.00 fee when people fail to keep their appointments or cancel without at least 24 hours notice.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Paul Neumann, DDS. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Print Name:_____

Date: _____

Patient's Signature: _____
(Parent if Minor)

R. Paul Neumann DDS
23811 Eden St.
Plaquemine, LA 70764

HIPAA Consent Form

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 healthcare 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 healthcare 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 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 you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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

Date Signed: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

INFORMED CONSENT

By state law we are required to inform you of possible risks associated with dental procedures. This form is an attempt to list the possible complications that could occur in association with dental treatment. These complications could be pain, swelling, discoloration, bleeding, numbness caused by damage to the nerve, infection, allergic reaction, shock (fainting), swallowing or aspiration of a foreign object, *brain damage, *less or loss of function of organ or limb, *cardiac arrest, *quadriplegic, and *death. All of these very serious complications (those with an asterisk) are very rare and have never occurred in this office. Certain dental treatments have complications associated with which are more prevalent and less serious than described above such as: Root or instrumental separation in root canal therapy, perforation with the removal of a tooth near the nasal sinus, fracture of root or bone with dental extraction, aggravation of jaw joint (TMJ) components caused by mouth opening, and root canal therapy being necessary for restorative procedures.

I fully understand the above and have had any questions answered to my satisfaction.

Print Name:_____

Date: _____

Patient's Signature: _____
(Parent if Minor)