GERMANTOWN DENTAL

Robert Cronk, DMD

Patient Information

Patient Name: _____ Date of Birth: _____
(First) (MI) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Please select one: ☐ Male ☐ Female Age: _____

Patient Employer/School: _____ Occupation: _____ Email: _____

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Best time to reach you is: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name: _____ Relationship: _____

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Please Select One: ☐ Married ☐ Divorced ☐ Single ☐ Minor ☐ Widowed

Spouse Name: _____ Spouse DOB: _____
(First) (MI) (Last)

Spouse Social Security #: _____ Spouse Employer: _____

How did you hear about us? _____

If referred, who may we thank for referring you? _____

Dental Insurance

Insurance Company: _____ Group # _____

Who is responsible for this account? _____ Union or Local # _____

Subscriber's Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to patient: _____

Employer: _____ Work #: (_____) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

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Dental History

Reason for today's visit: _____ Date of last dental visit? _____

Former Dentist: _____ Phone: (_____)_____ Date of last dental X-ray? _____

Check if you have or have had a problem with any of the following:

☐ Bad Breath ☐ Clicking or poppping jaw ☐ Grinding teeth ☐ Sensitivity to cold or hot

☐ Bleeding Gums ☐ Food collecting between teeth ☐ Loose teeth or broken fillings ☐ Sensitivity to sweets

☐ Sores or growths in your mouth How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name: _____ Date of last visit? _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (defenfluramine). ☐ Yes ☐ No

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, explain: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: _____

(Women only) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Check if you have or have had problems with any of the following: (Please check all that apply.)

☐ Anemia	☐ Congenital Heart Lesions	☐ Hepatitis	☐ Shortness of Breath
☐ Arthiritis, Rheumatism	☐ Cortisone Treatments	☐ Hernia Repair	☐ Skin Rash
☐ Artificial Heart Valves	☐ Cough, Persistent	☐ High Blood Pressure	☐ Stroke
☐ Artificial Joints, Pins	☐ Cough Up Blood	☐ HIV/AIDS	☐ Swelling of Feet or Ankles
☐ Asthma	☐ Diabetes	☐ Jaw Pain	☐ Thyroid Problems
☐ Back Problems	☐ Epilepsy	☐ Kidney Disease	☐ Tobacco Habit
☐ Bleeding Abnormally	☐ Fainting	☐ Liver Disease	☐ Tonsillitis
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Ulcer
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Veneral Disease
☐ Chemotherapy	☐ Heart Problems	☐ Rheumatic Fever	
☐ Circulatory Problems	☐ Hemophilia	☐ Scarlet Fever	

List of medications you are currently taking: _____

_____

Allergies:

☐ Aspirin ☐ Local Anesthetic ☐ Iodine ☐ Barbiurates (Sleeping Pills) ☐ None

☐ Latex ☐ Codeine ☐ Sulfa ☐ Penicillin **Other** _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

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Caries Risk Assessment Survey

High Moderate Low

Patient's Name: _____ Age:_____ Date:_____

Many of our patients express concern over having cavities. In fact, dental caries remains the most common threat to early childhood oral health. However, children are not the only ones at risk but many adults also face higher risk due to medical issues, dietary habits, and side effects from common medications.

The goal of this assessment form is to help us determine what your personal risk status is for decay. Please fill out the "Patient Use" section to the best of your ability. With this information, we will be able to discuss the appropriate preventive measures available to you to reduce your risk for cavities.

Risk Factors (Patient Use)

Do you notice plaque build-up on your teeth between brushing? ☐ Yes ☐ No

Do you take medication daily? If yes, how many? ☐ Yes _____ ☐ No

Do you feel like you have dry mouth at any time of the day? ☐ Yes ☐ No

Do you drink liquids other than water more than 2 times daily between meals? ☐ Yes ☐ No

Do you snack daily between meals? ☐ Yes ☐ No

Do you have oral appliances present? ☐ Yes ☐ No

Do any of these health concerns apply to you? (check all that apply) ☐ Frequent Tobacco Use ☐ Diabetes ☐ Recreational Drug Use ☐ Acid Reflux ☐ Bulimia ☐ Sjogren's Syndrome ☐ Head/Neck Radiation

Professional Assessment (Clinician Use)

Plaque/Calculus	Generalized	Localized	Minimal
New/Progressing Visible Cavitation	Yes		No
New/Progressing Radiographic Radiluncencies	Yes		No
Exposed Roots	Yes		No
Deep Pits of Fissures	Yes		No
White Spot Lesions	Yes		No
Cavity Diagnosed in the Last 3 Years	Yes		No
Uses Fluoride Toothpaste or Mouthwash	Yes		No
Drinks Fluoridated Water	Yes		No
Supplements Xylitol Gum/Mint	Yes		No

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NOTICE OF PRIVACY/CONSENT FORM

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 amount the multiple healthcare providers who may be involved in that treatment directly and indirectly; Obtain payments from third party payers; Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that my medical records including x-rays may be sent via protected or encrypted email or mail.

I understand that if I have a concern about the privacy of my medical records, I can contact Germantown Dental or concerns can be submitted directly to the United States Department of Health and Human Services.

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.

I give the staff of Germantown Dental permission to contact me by the following methods:

_____ Call me, including leaving a message on my voicemail or answering machine.

_____Send emails.

_____Send texts.

_____ Send post cards.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

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Financial & Insurance Policy

Please understand that the payment of your bill is considered part of your treatment, and we expect full payment at the time of service. We are in network with Medicaid and most other insurance companies. We accept cash, checks, MasterCard, Visa, and Care Credit. Patients under the age of 18 must have an adult (guardian) above the age of 21 accompany them, and the guardian is responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been made to make payments.

Each of the following is a statement of our financial & insurance policy, which is required to be read, initialed and signed prior to any treatment. Please initial below in agreeance to the following statements before signing:

____ I understand that payment is due at the time of services rendered, and I assume full responsibility for the bill incurred, including anything not covered by my insurance provider.
____ I understand that the estimate given is not guaranteed to be the exact amount, since benefits cannot be determinted until claims are filed.
____ I understand that dentistry is not an exact science and success cannot be guaranteed.
____ I understand that in the event of a returned check, a $35.00 insufficient funds fee will be assessed to my account.
____ I understand that if my account becomes 30 days past due, it will be subject to a 1.5% fee charged to my account.
____ I understand that if I do not make a payment toward my account within 90 days, I will be sent to collections and accrue a collections fee totaling up to 50% of the remaining balance on the account at the time of default.
____ I understand that if this account goes into default, I will be responsible for all court costs, attorney's fees, and any other associated fees.
____ I understand that it is my responsibility to provide accurate and up-to-date dental/medical insurance information.

In certain circumstances, insurance companies may send payment directly to the patient. In such cases, the patient agrees to endorse and send the check to Germantown Dental. If the patient deposits the check refunded from the insurance company into a personal account, the patient agrees to send a personal check for the equivalent amount to Germantown Dental within 10 days of the deposit.

Assignment of Benefits
I hereby assign all dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance, and any other health/medical plan, to issue payment directly to **Germantown Dental.** _____

Authorization to Release Information
I hereby authorize **Germantown Dental** to: (1) release any information necessary to the insurance carrier regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature and this form to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing. _____

I, _____, authorize **Germantown Dental** and affiliated associates and employees to perform any procedures deemed necessary during my treatment.

I have read the above financial & insurance policy. I understand and agree to the terms stated above.

X_____
Signature of Patient or Responsbile Party

Today's Date: _____

X_____
Name Printed of Patient or Responsible Party

**All appointments must be canceled 24 hours before the scheduled appointment or a $25.00 no show fee will be added to the patient's account.*
**This will serve as the responsible party's signature on file for the purpose of administering insurance benefits.*