

Adult Medical/Dental History

Patient Information

First Name *

Last Name *

Date of Birth *



Age

Gender *

Male Female Other

Address *

Address 2

City *

State *

Zip *

Home Phone

Cell Phone

Work Phone

Ext

Employer or School

How did you find about us? *

Preferred method of contact?

Phone Text/SMS Email

Emergency Contact

Cell Number

Relationship

Social Security Number

Approximate Height

Approximate Weight

For sedation and medication purposes

Medical Information

Have you had a recent exposure to any communicable infectious diseases? (Measles, Chicken Pox or Tuberculosis)

Yes No

In the last 24 hours have you had a new cough, shortness of breath, fever, chills, diarrhea or other flu-like symptoms?

Yes No

Have you previously been or are currently under the care of a health care professional for any kind of specific condition or syndrome?

Yes No

Do you require premedication prior to hygiene (cleaning) appointments or dental treatment?

Yes No

Please be sure to take your premedication prior to your appointment.

Have you ever had any major surgeries?

Yes No

Please explain

Are you taking any medications (including birth control, vitamins, etc.)

Yes No

Please explain

Do you have any known allergies?

Yes No

Please explain

FEMALES

Are you pregnant or nursing, or a possibility you could be pregnant?

Yes No

Please check any of the following below that you have ever had a bad reaction to

- Local Anesthetics
- Codeine
- Insulin
- Barbiturates
- Latex
- Metals

- Ibuprofen
- Penicillin
- Aspirin
- Iodine
- Other

Metals

Other

Have you had or do you have any of the following?

- Anemia
- Stroke or Blood Clots, Bleeding Easily
- Blood Transfusions
- Heart Disease
- Artificial Heart Valve
- Congenital Heart Defects
- Rheumatic Heart Disease
- Angina
- Heart Attack
- Chest Pain
- Pacemaker
- Tuberculosis
- Asthma
- Hay Fever
- Emphysema
- Pneumonia
- Pleurisy
- Thyroid/Adrenal Disease

- Cancer
- Chemotherapy
- Radiation Therapy
- Hepatitis/Jaundice
- Drug/Alcohol Dependency
- Mental Illness
- HIV
- Heart Murmur
- High Blood Pressure
- Rheumatoid Arthritis
- Eye Disorders
- Epilepsy
- Seizures
- Malignant Hyperthermia
- Kidney Disease
- Diabetes
- Smoker
- Pins, plates, replacement joints

| | |
|------|--|
| Date | |
|------|--|

Dental Information

Last dental check-up/cleaning?

How often do you visit the dentist?

How often do you brush your teeth?

How often do you floss your teeth?

Are you having any problems that require immediate attention?

Yes No

Please explain

Do any of the following cause tooth discomfort?

- Sweets
- Hot
- Cold
- Chewing

Do you clench or grind your teeth?

Yes No

Have you ever had orthodontic treatment (Braces or Invisalign)?

Yes No

Are you interested in straightening your teeth?

Yes No

Have you ever considered straightening, bleach, crowns or veneers?

Yes No

Do you have spaces you would like closed?

Yes No

How do you feel about the appearance of your teeth?

Is there anything else you wish to share/discuss about your teeth or smile?

Primary Insurance

Your insurance company/carrier

Insurance Address

Secondary Insurance (If Applicable)

Your insurance company/carrier

Insurance Address

Insurance Phone Number

Employer

Policy holder's name

Policy holder's date of birth

Group or policy number

I.D./Certificate number

Insurance Phone Number

Employer

Policy holder's name

Policy holder's date of birth

Group or policy number

I.D./Certificate number

I authorize release to my dental benefits plan administrator and the ADA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

I authorize my insurance company to make payment directly to this dental provider.

As you may know your insurance covers only a percentage of the total fee of services provided and we therefore require a credit card number to accept assignment from your insurance carrier. This is with the understanding that our office will be calling you for authorization to use this credit card to pay the difference not paid by your insurance provider.

I understand that anything not covered by my dental insurance is my full responsibility to pay. Our office will help to provide the most accurate estimate possible, but it is ultimately the patients responsibility to know what their insurance coverage details are.

I understand that your office requires me to give **24 hours notice** prior to cancelling or rescheduling my appointments. If I fail to do so or fail to come to my appointment a **\$50 fee** may apply. As a courtesy our office will send an email/text appointment reminder to you.

Name and Email of Signing person

First & Last Name *

Email Address *

Signature *



Sign above

Financial and Insurance Policy

Patient Information

First Name *

Last Name *

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Outside financing is available upon request and approval.

Please note: Additional fees will be applied for returned checks. All account balances over 90 days are subject to a \$35.00 late fee.

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian

The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

Unaccompanied Minors

The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Missed Appointment (s) and Cancellations

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 48 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments.

Consent

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Name and Email of Signing person

First & Last Name *

Email Address *

Date

Signature *

Sign above

Submit

HIPAA Consent

HIPAA is a federal law developed to give individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication of PHI that may be made by alternative means or correspondence.


The purpose of the Notice of Privacy Practice is to explain how Taos Dental Group may use or disclose your health care information. This Notice also explains the rights that you are guaranteed under HIPAA regulations. All information provided on this form is part of your Protected Health Information and will NEVER be shared with a 3rd party.

Patient Information

First Name *

Last Name *

Date of Birth *

Please provide us the best phone number(s) to contact you

Home Phone

Cell Phone *

Work Phone

Ext

May we call the phone number(s) above and leave detailed voice messages regarding your appointments, billing matters and/or medical information?

Yes No

Would you like to be notified of and confirm appointments via text messages?

Yes No

Would you like to be notified of and confirm appointments via emails?

Yes No

Would you like to receive special offers or internal promotions via emails?

Yes No

Please list the person(s) you give permission to us to disclose your appointments, billing matters and or medical information with

Name

Relationship

Name

Relationship

Name

Relationship

****You may refuse to sign this acknowledgement****

By signing below, I hereby acknowledge that I have received a copy of Taos Dental Group's Notice of Privacy Practice. I have read and understand this HIPAA privacy rule. I have also agreed to allow Taos Dental Group and the employees thereof to relay detailed messages regarding my appointments, billing matters and or medical information to myself or the above named representatives as specified.

Name and Email of Signing person

First & Last Name *

Email Address

Date

Signature

Sign above

Submit