PATIENT INFORMATION FORM

Identification

Please text a picture of the patient's photo ID to (417) 409-1410 (or provide it to the front desk for scanning).

First Name: Middle Initial: Last Name: Preferred Name:

Gender: Birthdate: Social Security #:

Contact Information

Cell #: Home #: Work #: Email:

Address: City: State: Zip:

Additional Information (Circle all that apply)

Patient's marital status: Single/Married/Divorced/Widowed/Significant Other

How did you hear about us? Drive-By/Friend/Family/Co-Worker/Google/Insurance List/Social Media/Other

Appointment Preference: AM PM NONE

Available on short notice? YES NO

Communication Preferences

☐ Text me ☐ Email me ☐ Call me ☐ Send me appointment reminders

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Patient Status (Circle all that apply)

Employed: Full-Time Part-Time N/A
Student: Full-Time Part-Time N/A

Emergency Contact

Name: Phone: Relation:

Financial Responsibility

Circle who is responsible for the patient's account: SELF SPOUSE FATHER MOTHER OTHER

Insurance Information

Does the patient have insurance? YES NO (If yes, please fill out the attached Insurance Information Form.)
Is the patient the policy holder? YES NO

INSURANCE INFORMATION FORM

Please text a screenshot or picture of the front and back of your DENTAL (not medical) insurance cards to: (417) 409-1410, or hand your cards to the front desk so they can make a copy.

Policy Holder First Name: _____

Policy Holder Last Name: _____

Policy Holder Social Security #: _____

Policy Holder Birthdate: _____

Relation to Patient: _____

Policy Holder Employer: _____

Insurance Company Name: _____

Company Name on Card: _____

Group #: _____

Subscriber # or Member ID #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Secondary Insurance

Do you have secondary insurance? ☐ YES ☐ NO

(If yes, please request an additional copy of this form from the front desk.)

Authorization

By signing below I certify that I (or my dependent) have insurance coverage and assign directly to this dental office all insurance benefits payable. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize release of information necessary to secure payment and the use of this signature on all submissions.

➔ **Print Patient/Guardian Name** _____ **Patient Date of Birth** _____

➔ **Signature of Patient/Guardian** _____ **Today's Date** _____

FINANCIAL POLICY

I understand and agree that:

Ø All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.
Ø Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days interest at 9% per annum may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.
Ø A returned check fee may also be applied in the amount of $25 and must be payable from you for each check payment returned to us by your bank.
Ø Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider.
Ø If there is dental insurance on the account, I understand that the clinic has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.
Ø Estimates and treatment plans are based upon information gained from the examination and are not final. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only. Insurance coverage and lab charges (if applicable) have been estimated and included in the total.
Ø Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.
Ø A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.
Ø I understand that if it becomes necessary to refer my account to a collection agency, or legal counsel, that I will be responsible for all costs of collection; including all legal fees and court costs. I also understand that I can be reported to the credit bureau if I fail to meet my financial obligations.
I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.
Ø I understand that if I choose to pay with a credit card, I will be charged a convenience fee of 3.5% of my total payment.

➔ **Patient/Guardian Initials:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received/was offered a copy of the Notice of Privacy Practices for this office.

➔ **Patient/Guardian Initials:** _____

OFFICE POLICY

This letter is to inform our patients of the establishment of a new office policy. As some of you have noticed, our practice is growing. We strive to provide quality care at a reasonable cost. Wasted appointment time is a major cost to our office and has become a growing issue. Because of this we are instituting the following:

Ø Our office asks for 48 hours notice for any cancellation or rescheduling of appointments. (Our office is closed on Fridays. If your appointment is scheduled for a Monday, we will need to hear from you by the previous Thursday.)

Ø Our office will allow 2 canceled or failed appointments in a years' time.

Ø After 2 canceled or failed appointments, it will be required that the patient pay a $50 prepay per hour of chair time before booking any future appointments.

Ø Missed or canceled appointments within 48 hours prior to the appointment time will result in the loss of the prepay.

Ø The prepay will always go towards services rendered or refunded if filing with insurance.

Fortunately, this will not be a problem for most. We are instituting this policy to try to eliminate costly "dead" chair time for our doctor and his staff. Thank you for understanding and cooperating. We look forward to caring for you.

➔ **Patient/Guardian Initials: _____**

CONSENT TO DENTAL TREATMENT

You have the right to accept or reject dental treatment recommended by Dr. Hassenplug. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, and alternative treatments or the option of no treatment. It is very important that you provide the Dentist with an accurate medical history before, during, and after treatment. It is equally important that you follow the Dentist's recommendations and advice regarding medication, pre and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled follow-up appointments. If you fail to follow the advice of the Dentist, you may increase the chances of a poor outcome or dismissal from the practice. Please read the items below and sign at the bottom of the form.
Do not sign this form or agree to treatment until you have read, understood, and accepted each item carefully. Be certain the Dentist has addressed all of your concerns to your satisfaction before commencing treatment.

1. DENTAL CARE. The following care may be provided to you during your course of treatment:
   - Examinations and X-Rays: Radiographs are required to complete your examination, diagnosis, and treatment plan. A periodic examination will be provided by the Dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer, and overall health. The Dentist will read and diagnose any x-rays taken.
   - Dental Prophylaxis (Cleaning): A routine dental prophylaxis involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature, the office should be contacted.
   - Restorations (Fillings): A more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure that can only be found during preparation of the tooth. This may lead to root canal, crown, or both. Sensitivity is a common aftereffect of a newly placed filling. Occasionally after receiving a filling, it may feel high and you may need to return to have the bite adjusted.

- Periodontal Treatment: Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is scheduled, the dental hygienist and Dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment, it may be necessary for more extensive treatment to be performed. The dental hygienist will stop the routine cleaning and explain to you alternative treatment plans including nonsurgical cleaning below the gum line, placement of an antibiotic below the gum line, or a gross debridement (two-part cleaning). If further treatment such as gum surgery and/or extractions are necessary, a comprehensive periodontal exam will be scheduled with our periodontist. The success of any periodontal treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow any other recommendations. Some bleeding after deep cleanings or scaling under the gum line can occur, however, should it persist and if it is severe in nature, the office should be contacted. Untreated periodontal disease may have a future adverse effect on the long-term success of dental restoration work.
- Crowns, Bridges, and Veneers: It is not always possible to match the color of natural teeth exactly with artificial teeth. A temporary crown will be made after the initial preparation appointment. Temporary crowns may come off and you should be careful chewing on them until the permanent crowns are delivered. If a temporary crown should fall off, call the office immediately. The final opportunity to make changes on crowns, bridges, or veneers (including shape, fit, size, placement, and color) will be done before permanent cementation. In some cases, crowns, bridges, and veneer procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. After a crown, bridge, or veneer is permanently cemented, sometimes your bite may feel high and you may need to return to have the bite adjusted or fixed. Modification of daily cleaning procedures may be required, and if so, will be explained to you by the provider.
- Temporomandibular Joint Dysfunction (TMD). Symptoms of popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment when the mouth is held in the open position. However, symptoms of TMD associated with dental treatment are usually temporary in nature and well tolerated by most patients. If the need for treatment should arise, you will be referred to a specialist, the cost of which is your responsibility.

2. CHANGES IN TREATMENT PLAN. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
3. ALLERGIES/MEDICATION. I have informed the Dentist of any known allergies I may have. I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain, or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).
4. CONSENT. I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure. I also understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

➔ **Patient/Guardian Initials:** _____

PATIENT DISCLOSURE AUTHORIZATION FORM

I authorize disclosure of my protected health information such as insurance information, proposed treatment, outstanding account balances, and medical history to the following individuals:

(Please print the names of up to four people. This can include a spouse, parents, power of attorney, caregiver, etc. You do not need to include other healthcare providers.)

1. _____

2. _____

3. _____

4. _____

By signing this I acknowledge that I understand and agree to the Financial Policy, Office Policy, Consent to Dental Treatment, Privacy Practices and Disclosure Authorization and that these are valid until revoked. I, the undersigned, also certify that the information I have provided is accurate to the best of my knowledge. If I (or my dependent) have insurance coverage, I assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

➔ **Print Patient/Guardian Name** _____ **Patient Date of Birth** _____

➔ **Signature of Patient/Guardian** _____ **Today's Date** _____

Driftwood Dental

Patient Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Do you have a primary doctor? Who?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you have a preferred pharmacy? Name?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

☐ Trying to get pregnant?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Peanuts	☐ Gluten	☐ Dairy	

Do you use controlled substances?	◯ Yes ◯ No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Hepatitis C	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Seasonal Allergies	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____