Timpview Dental

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Timpview Dental Consent Form, Financial Policy & HIPPA Agreement I here by authorize and request the performance of dental services for myself and the following dependent. (s)

Patient _____ Date of Birth _____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes of dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself of the above named, regardless of insurance coverage. I understand all prices quoted by the dentist of staff are estimates dependant upon insurance and not the set price.

I understand that payment is due at the time of service. In the event that payment in full for charges incurred is not made, I agree to pay for all costs of collection including a 33% collection fee, attorney fees, court costs and interest at the rate of 1.5% per month (18% per year). Payment is accepted in the form of Cash, Check, Visa, MasterCard, and Care Credit.

I understand that a fee of $25.00 will be charged for a missed appointment unless I notify the office 24 hours in advance.

HIPPA I understand that, under the health insurance portability & accountability act of 1996 (HIPPA), have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved I that treatment directly and indirectly.

Obtain payment front third party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description for the uses and disclosures of my health information, I have been given a copy of your Notice of Privacy Practices prior to signing this consent. 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 any the address above to obtain a current copy of the Notice of Privacy Practices.

I have read, understand, and agree to the provisions of this financial policy/consent form/HIPPA agreement.

_____

Signature of Responsible Party Date

_____

Witness Date

Dental Radiographs (X-Rays)

Small amounts of radiation are used to make pictures of teeth (radiographs). These black and white images show various shades of gray because some portions of teeth or dental restorations let more or less of the radiation pass through. The result is a picture that shows the presence of dental decay and other pathology. It is nearly impossible to diagnose the presence of decay between the teeth without using dental radiographs. By using radiographs, small areas of decay can be identified before the decay process endangers the life of the tooth.

There are two types of dental radiographs, digital and conventional (analog). The newer form of radiographs are digital, which allow faster observation of the images with very low radiation.

Some people are worried about the radiation used in dentistry. Dental radiographs use a very small amount of radiation and it is directed exactly to the site where it is needed. The amount of radiation required for one dental radiograph (bitewing or periapical) is about the same amount of radiation you receive by standing in a parking lot in the sun for a few minutes, or riding on an airplane for a few minutes. The fear of dental radiographs, which are used with caution and good judgment, is totally unfounded. The extremely minimal amount of radiation present in dental radiographs is far outweighed by the diagnostic advantage provided by the radiographs.

I have read and understand the above information.

PATIENT'S NAME	SIGNATURE OF PATIENT, LEGAL GUARDIAN, OR AUTHORIZED REPRESENTATIVE	DATE

Anesthetics for Oral Treatment

The following methods are available to control discomfort experienced during oral treatment. Please discuss your preference with us. Advise use of any medications you are taking in case they conflict with the following anesthetic methods:

1. **Local Anesthetic:** This type of anesthetic is by far the most common form used in dentistry. You will receive a nearly painless injection of a short-acting (one hour), long-acting (three hours), or extra-long-acting (up to six hours) local anesthetic. Almost no side effects result. Unless you have special preference, local anesthetics will be used for your dental services. There is not an additional fee for this service.

2. **General Anesthetic:** Certain conditions require the use of general anesthetic, usually in a hospital environment. If this is necessary for you, usually an anesthesiologist or anesthetist will deliver the anesthetic while the dentist completes the oral treatment. You will be billed by the personnel delivering the anesthetic for that service, and by our office for the oral treatment.

3. **General Anesthetic in a One-Day Surgicenter:** If your health is excellent, and if your oral condition requiring general anesthetic is less severe, you may be treated in a surgicenter. The overall cost will be less than the same services in a hospital, but will still include the following fees: anesthesiologist or anesthetist fee, surgicenter fee, and the dentist's fee.

4. **Nitrous Oxide:** Nitrous oxide gas, or "laughing gas" is a colorless non-flammable gas with a pleasant, slightly sweet odor and taste that reduces the sensation of pain and creates a euphoric feeling. There is no "hangover" effect. The effect is eliminated from the body within 3–5 minutes after the gas supply has stopped. You may drive home without an escort. Some patients still feel discomfort using nitrous oxide, and they require augmentation of local anesthetic. Nitrous oxide is not recommended for pregnant patients, patients who might be pregnant, and patients who suffer from emphysema.

5. **Sedatives:** If you are very anxious or nervous about oral treatment, please ask us about pre-medication. This medication may be given to you to take before you arrive, or it may be provided to you about one-half hour before the treatment begins. You should plan to arrive one-half hour early and have someone present to drive you to your home.

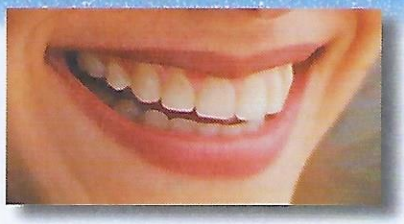
6. **Electronic Anesthesia:** Transcutaneous Electrical Nerve Stimulation (TENS) provides a very slight amount of electricity to the area to be anesthetized and produces non-chemical anesthesia for 70 percent or more of the patients. Initially, this procedure requires slightly more time than chemical anesthetics for effectiveness. However, on later appointments, it is faster than injected local anesthetics. Electronic anesthesia is harmless and has no after effects or post-operative "numbness."

7. **Hypnosis:** In very special situations that do not adapt to any other anesthetic modes, hypnosis may be effective. This procedure usually requires more time on each appointment and more appointments than for other types of pain control. A fee is charged for this service.

Please ask us questions about any of these services.

I have read and understand the above information.

PATIENT'S NAME	SIGNATURE OF PATIENT, LEGAL GUARDIAN, OR AUTHORIZED REPRESENTATIVE	DATE



Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Patient's Sex ☐ F ☐ M

Name First _____ Last _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

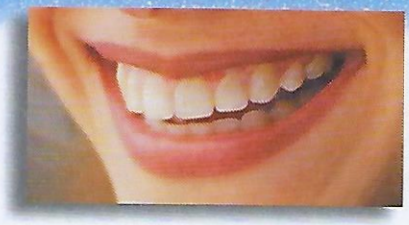
Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please



Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

Payment is due in full at the time of treatment *unless prior arrangements have been approved.*
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.
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 that I may need during diagnosis and treatment, with my informed consent.

X _____ _____

Signature of patient (or parent/guardian if n Date

TIMPVIEW DENTAL

Established Patient - Medical History Update

To ensure the highest quality of healthcare, we ask that you complete this patient update form. ***Note:*** **If you have not been seen in our office for over a year, a new complete medical history is required.**

TODAY'S DATE: _____/_____/_____

Patient Name:		**Date of Birth:**
Why are we seeing you today?	☐ **Follow Up Visit**	☐ **Other:** _____
Preferred Method of Contact:		
☐ **Email Address #:** _____	☐ **Home #:** _____	☐ **Cell #:** _____
Home Address:		**Zip Code:**

	NO	YES	IF YES, PLEASE EXPLAIN:
Any changes in Dental Insurance?	☐	☐	
Has there been any change in your health since your last appointment?	☐	☐	
Have you had any Major Health Issues, Surgeries or Hospitalizations since your last visit?	☐	☐	
Has there been any change in your dental health since your last appointment?	☐	☐	
NEW family history of cancer or other health issues since your last visit?	☐	☐	
Are you taking any kind of medications &/or supplements - prescription & /or non-prescription?	☐	☐	
Have you ever taken bisphosphonates, antiresporptive, or antiangiogenic drugs (medicine that effects bone growth or metabolism)?	☐	☐	
Are you Allergic to any medications, foods, or latex?	☐	☐	
Do you use any tobacco products?	☐	☐	

FEMALE ONLY

Are You Pregnant:	☐ ***Yes***	☐ ***No***
Are You Taking Birth Control	☐ ***Yes***	☐ ***No***

I Certify *that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.*

X	**X**	**X**	**X**
Signature of Patient (Parent of Guardian if Minor)	**Date**	**Reviewed By Staff** (Signature)	**Date**