ESCALA FAMILY DENTISTRY
Family, Cosmetic & Implant Dentistry

Confidential Patient Information

Date _______________

PERSONAL INFORMATION

Name ______________________________________
Social Security # ____________________________
Address ____________________________________
____
City _______________________________________
State ___________________ Zip______________
Home Phone # ______________________________
Work Phone # ______________________________
Cell Phone # _______________________________
Emergency contact name ____________________
Emergency contact Phone # __________________
E-mail _____________________________________
Birth date ___________________ Sex _________
Marital Status ______________________________
Spouse name _______________________________
Occupation ________________________________
Languages you speak _______________________
How did you hear of our office? ______________
____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _______________________
Insurance Co. Address _______________________
Insurance Co. Phone # _______________________
Employee (Policy Holder) ____________________
Relationship _____________________________
S.S. # of Policy Holder _______________________
Birth date of Policy Holder __________________
Employer __________________________________
Policy # ___________________________________

Secondary Insurance Co. _____________________
Insurance Co. Address _______________________
Insurance Co. Phone # _______________________
Employee (Policy Holder) ____________________
Relationship _____________________________
S.S. # of Policy Holder _______________________
Birth date of Policy Holder __________________
Employer __________________________________
Policy # ___________________________________

PERSON RESPONSIBLE FOR ACCOUNT (If same as above, skip to next section)

Name _______________________________ Relationship ____________ S.S. # ______________________
Address ____ City _____________ State _____ Zip _______
Telephone (Home) ___________________ (Work) ____________________ (Cell) ___________________

DENTAL HISTORY

Reason for today's visit ____
Former Dentist _________________________________ Date of last dental visit ______________________

I understand that payment is my obligation regardless of insurance or any other third party involvement.

SIGNATURE ____ **DATE** ______________

MEDICAL HISTORY

Patient name ____ Birth date ________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your 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 completely and honestly.

PLEASE EXPLAIN ANY "YES" RESPONSES ON THE LINES PROVIDED.

Are you under a physician's care now? ___Yes ___No ____________________________________
Have you ever been hospitalized or had a major operation? ___Yes ___No ____________________________________
Have you ever had a serious head or neck injury? ___Yes ___No ____________________________________
Are you taking any medications, pills, drugs, or vitamins? ___Yes ___No ____________________________________
Please list all medications you currently take ____
____
Do you take, or have you taken, Phen-Fen or Redux? ___Yes ___No
____
Have you ever taken Fosamax, Boniva, Actonel
or any other medications containing bisphosphonates? ___Yes ___No ____________________________________
Are you on a special diet? ___Yes ___No
____
Do you use tobacco? ___Yes ___No ____________________________________
Do you use controlled substances? ___Yes ___No ____________________________________

FOR WOMEN ONLY: Are you…

Currently pregnant? ___Yes ___No
Trying to get pregnant? ___Yes ___No
Taking oral contraceptives? ___Yes ___No
Nursing? ___Yes ___No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

___Aspirin ___Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Metal ___Latex ___Sulfa drugs
___Other (please explain) ____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
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 or C	___Yes	___No	Renal Dialysis	___Yes	___No
Anemia	___Yes	___No	Easily Winded	___Yes	___No	Herpes	___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/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	Shingles	___Yes	___No
Artificial Joint	___Yes	___No	Excessive Thirst	___Yes	___No	Hypoglycemia	___Yes	___No	Sickle Cell Disease	___Yes	___No
Asthma	___Yes	___No	Fainting/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 Problem	___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 ____________________________________

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 the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian ____________________________________ **Date** ________________

ESCALA FAMILY DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____
Printed Name

____
Signature

____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify) ____

ESCALA FAMILY DENTISTRY
OFFICE POLICIES

We very much appreciate and value you as a patient in our practice. So that we may continue to have an excellent, mutually beneficial relationship, we would like to take this opportunity to reiterate our office expectations.

As a patient of our practice, we expect you to:

- **Keep your scheduled appointments. We do require a two (2) business day notice for any appointment changes or cancellations. Failure to notify us within two business days will result in a $50 cancellation fee.** Initials __________
- Arrive on time for your appointments. We will wait up to 15 minutes for you to arrive, if you do not show up, your appointment will be cancelled.
- If you have insurance, pay your estimated insurance portion at the time services are rendered.
- If you do not have insurance, pay for your services at the time they are rendered.
- Provide us with current and accurate insurance information.
- Keep us updated regarding changes in your personal information, such as address and telephone number.
- Notify us of changes of your general health status, including any special needs that you may have.
- Feel comfortable referring your friends and family members to our office.

INSURANCES WILL ONLY GIVE US AN ESTIMATE OF YOUR BENEFITS. YOU ARE RESPONSIBLE FOR VERIFICATION OF COVERAGE.

Insurance plans represent a contract between yourself and the insurance company. These contracts are not between the doctor and the insurance company. We will do our best to help you obtain benefits, but we cannot be responsible if your carrier does not pay. Further, if a member of our staff advises you that you are not fully covered or implied that you will owe nothing, it is your responsibility to contact your insurance company for verification. Therefore, it is your responsibility to make certain your carrier makes prompt payment, and to handle any disputes that may arise.

If your insurance is found not to be in force on the date dental services are provided, you will be responsible for the full balance.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection to any claim associated with me.

If my account is placed with a collection agency for non-payment, I will be responsible for all collection costs, including court costs and associated attorney fees.

I authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist or dental entity associated with this office policy.

I have read the office policies of Escala Family Dentistry and agree with all the terms and conditions outlined above and an opportunity to answer any questions was given to me.

Responsible Party Signature ____ Date__________________

Printed Name ____

We strive to give all patients the same care. We will help all patients with their insurance claims. It ultimately is the patients responsibly to know about the insurance. If you have any concerns with what they are paying it is the patients responsibility to contact them directly.

Insurance Financial Waiver

All patients that have dental insurance are allowed so much for the year. Any portion that is not covered by their insurance company, it is the patient's responsibility to pay the remainder balance.

Medicaid Financial Waiver

All adult Medicaid patients are allowed $1000.00 for the fiscal year (July 1st- June 30st). All children up to the age of 21 don't have a yearly max. For any reason that Medicaid does not pay for their treatment, it is patient's responsibility to pay for the remainder balance.

Signing this states that you are aware that you as a patient and/or guardian is responsible for the financial portion that your insurance does not cover.

Thank you,

____

Patient