Nature's Way Dentistry

Patient Information

Name _____ Address _____

City _____ State _____ Zip _____

Phone _____ _____ _____

Preferred Home ☐ Cell ☐ Business ☐

Email _____

Confirm appointments via Text ☐ Email ☐ Call ☐

If text option selected, provider

AT&T ☐ Verizon ☐ Sprint ☐

T-Mobile ☐ Other _____

If you select confirm via text, you are agreeing to pay for any related charges

Birthdate _____ SSN _____ Gender F M

Marital Status Married ☐ Single ☐

Employer _____

Employee Status FT ☐ PT ☐

Occupation _____

Primary Dental Insurance (Name of Company) _____

Policy Holder Self ☐ Spouse ☐ Parent ☐

Policy Holder Name (If different than self) _____

Insurance ID _____

Group Number _____

Policy Holder's Birthdate _____

Policy Holder's SS# _____

Consent For Disclosing Personal Health Information:

Relation: Self ☐ Spouse ☐ Parent ☐

Name of Authorized Person: _____

Phone Number: _____

What Can We Disclose? _____

Sign and Date: _____

How did you hear about us? (If refered by a friend, include their name).

_____

Nature's Way 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
(PLEASE PRINT YOUR NAME)

Notice of Privacy Practices.

_____

Signature

_____

Date

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify:

_____

_____

_____

Last Updated 01 October 2015

Appointment Policy

Instruments, chairs and personnel are reserved exclusively for your appointment. Last-minute cancellations and no-shows are expensive to our patients and our practice. **No-shows, cancellations day of, or appointments cancelled less than 2 business days in advance are considered failed appointments and are subject to immediate dismissal including new prospective patients.**

- We understand that extenuating circumstances occur, so the **1st failed** dental appointment incurs a warning. After a failed appointment, a 50% copay deposit is required to reserve an appointment.

This charge is not a penalty. It is a portion of your copay charged at the time your appointment is scheduled. Your copay deposit will directly apply to your treatment at the time of your visit. Your copay deposit is not refundable. Should you fail your appointment, your copay will be forfeited in addition to a $50 cancellation fee.

- After a **2nd failed** appointment, paying 100% in full before scheduled appointments is required to reserve for the next appointment.
- After a **3rd failed** appointment, will result in dismissal from our office.

A 3rd failed appointment will result in dismissal from Nature's Way Dentistry. ***Our office is appointment-based, and cannot provide this level of flexibility in our schedule.*** We will assist you in finding another dentist to accommodate your scheduling needs.

Our appointment policy exists to keep costs down. Nature's Way Dentistry is proud to offer the highest level of care, the highest quality materials and the best patient experience in the area. We are also proud to offer these services at a reasonable cost. Above all, failed appointments are expensive to our patients, our practice and we cannot accommodate failed appointments into our business model.

I, _____, agree to these terms.

Signature _____ Date_____

Financial Agreement

PATIENT PORTION IS DUE AT TIME OF SERVICE; YOU WILL BE REQUIRED TO PAY TODAY.

If you cannot pay for your appointment today, payment arrangements must be made before your scheduled appointment. **Payment options:** 1. Check 2. Credit card 3. Payment plan with Care Credit.

I understand that I am responsible for all charges for the care I receive. If I do not have dental insurance coverage, I will pay all amounts for which I am responsible in full, at time of service of treatment. It is my responsibility to provide accurate and up to date information regarding my dental insurance coverage. Failing to do so may result in being responsible for 100% of payment.

PATIENTS WITH INSURANCE: As a courtesy we will do an eligibility check to see if you are covered. You have (7) days to provide us with the correct dental insurance information; otherwise, we will bill you directly for the full balance of your appointment and the balance is your responsibility.
The PATIENT is responsible for the non-covered portion of procedures and/or deductibles at the time of service. The quote for treatment cost provided to you is an **estimate. Treatment costs may be higher or lower than the estimate.** If the insurance company does not pay after 60 days, we will bill you directly for the full balance. After insurance has paid their portion, and there is any cost remaining, you will get a statement with the remaining balance and it is your responsibility to pay in the time stated on the statement.

PATIENTS WITH OUT OF NETWORK INSURANCE: If my treating dentist is not a participating provider with my insurance, I will be required to pay for all treatment in full, at time of service. The practice may file for insurance coverage as a courtesy. If any coverage is paid, payment will be reimbursed directly to you from your insurance company.

If you have questions about your insurance coverage, we are happy to provide a pre-authorization for coverage, at your request. This is just an estimated quote of cost for treatment and is not a guarantee. Any other questions regarding coverage should be addressed though your insurance company.

- **Parents not accompanying their children** to an appointment must make prior arrangements for payment.
- **Parents accompanying their children** are financially responsible for payment.
- There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$50.00 charge for changed or broken hygiene and restorative appointments less than 2 business days in advanced.**

PATIENTS WILL BE CHARGED THE FULL AMOUNT FOR CROWN, ROOT CANAL AND 2 HOUR OR GREATER APPOINTMENTS CANCELLED LESS THAN 2 BUSINESS DAY'S IN ADVANCE.

REFUND POLICY
No refunds will be granted for services or procedures already preformed at this office. Patients may cancel treatment with no charge if the appointment is cancelled 2 or more business days before the natural teeth are prepared or altered. **After tooth preparation has occurred, patients are liable for the full cost of services if they choose to not complete treatment.**
I authorize my insurance benefits be paid directly to the physician; I understand that I am financially responsible for any balance. I also authorize Nature's Way Dentistry or my Insurance company to release any information required to process my claims.

Signature _____ Date _____

Name (printed) _____

Medical Health History:

All information is strictly confidential but required for optimal treatment

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

	Yes
Heart Problems	
Chest Pain	
Shortness of breath	
Blood pressure problem	
Heart murmur	
Heart valve problem	
Taking heart medication	
Rheumatic fever	
Pacemaker	
Artificial heart valve	
Blood Problems	
Easy bruising	
Frequent nosebleeds	
Abnormal bleeding	
Blood disease (anemia)	
Allergy Problem	
Hay Fever	
Sinus problems	
Skin rash	
Taking allergy medication	
Asthma	
Intestinal Problems	
Ulcers	
Weight gain or loss	
How much? _____	
Over how long? _____	
Special diet	
Constipation/Diarrhea	
Kidney or bladder problems	
Bone or Joint Problems	
Arthritis	
Rheumatoid	
Back or neck pain	
Joint replacement	
Which joint? _____	
Fainting Spells, Seizures, or Epilepsy	
Stroke(s)	
Frequent or severe headaches	
Thyroid problems	
Hypothyroid	
Hyperthyroid	
Mild Moderate Severe	
Persistent cough or swollen glands	
Premedications required by physician	
Cancer/Tumor	
Type of cancer and location: _____	
_____	
Date Diagnosed: _____	

	Yes
Diabetes: Please note Type I or Type II: _____	
Current Average Blood Sugar Reading: _____	
Thirsty or mouth is dry much of the time	
Family history of diabetes	
Tuberculosis or other respiratory disease	
Do you drink alcohol?	
If so, how much? _____	
Do you smoke?	
If so, how much? _____	
Hepatitis, jaundice, or liver trouble?	
Sexually Transmitted Disease	
If yes, what _____	
HIV-positive/AIDS	
Glaucoma	
History of head injury?	
Epilepsy or other neurological disease?	
History of alcohol or drug abuse?	
Do you have a disease, condition, or problem not listed previously that you feel we should know about?	
If so, please describe: _____	

During the last 12 months have you taken the following?	
Antibiotics or sulfa drugs	
Anticoagulants (e.g. Coumadin)	
High blood pressure medicine	
Tranquilizers	
Insulin, Orinase, or similar drug	
Aspirin	
Digitalis or drug for heart trouble	
Nitroglycerin	
Cortisone (steroids)	
Natural remedies	
Nonprescription drug/supplements	

Women	
Are you taking contraceptives or other hormones?	
Are you pregnant?	
If so, expected delivery date: _____	
Are you nursing?	
Have you reached menopause?	

Have you adversely reacted to any of the following: **If yes, please list the type of reaction on line.**	
Local anesthetics ("Novocain")	
Penicillin or other antibiotics	
Sulfa drugs	
Barbiturates, sedatives, or sleeping pills	
Aspirin, Acetaminophen, or Ibuprofen	
Codeine, Demerol, or other narcotics	
Reaction to metals	
Latex or rubber dam	
Have you ever taken Fosamax or other osteoporosis drugs?	
If yes, what _____	
Other: _____	

Signature: _____ DATE: _____

Current Medications

Please list any current or previous medications. More space is provided on the back of this sheet if necessary.

Medication	Dosage	Frequency

Dental Health History

All information is strictly confidential but required for optimal treatment

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

	Yes
Does food catch between your teeth	☐
Do you have difficulty chewing your food	☐
Do you avoid brushing any part of your mouth because of pain?	☐
Do your gums bleed easily?	☐
Do your gums bleed when you floss?	☐
Do your gums feel swollen or tender?	☐
Have you ever noticed slow healing sores in or around your mouth?	☐
Are you teeth sensitive to:	
Hot foods or liquid?	☐
Cold foods or liquid?	☐
To sweets?	☐
Do you take fluoride supplements?	☐
Are you dissatisfied with the appearance of your teeth?	☐
How often do you brush?	
How often do you floss?	
Are you aware of an uncomfortable bite?	☐
Have you had a blow to the jaw (trauma)?	☐

	Yes
Do you clinch or grind your jaw:	☐
During the day?	☐
During the night?	☐
Does your jaw ever lock?	☐
Does it hurt when you chew or open wide to take a bite?	☐
Do your jaw joints ever ache?	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐
Do you take medications or pills for pain or discomfort? (Pain relievers, muscle relaxants, antidepressants)	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐
Why and what area?	

Treatment Policy

Please read each statement for understanding of our office treatment policies

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary.

I fully understand that doing dental procedures, standard cleanings, and using anesthetic agents and doing injections embodies certain risks, and though rare, I accept the danger of such risks.

I understand that I can ask for a complete recital of any possible risk at anytime.

I certify that I have read, understood, and agree to the above treatment policy and information in this packet. I have been given the opportunity to ask any questions and the staff at Nature's Way Dentistry has answered them to my understanding. The information in this packet is filled out to the best of my knowledge and I understand that providing incorrect information can be dangerous to my health.

Name (Printed) _____ Date: _____

Signature: _____