HOLDREGE
DENTAL ARTS

New Patient Checklist

To help you prepare for you first visit at our office, we have created a list of items you need to bring with you to your appointment.

_____The following forms filled out and signed

- **New Patient Information**
- **Medical History Form**
- **Financial Policy**
- **HIPPA Consent From**

_____ Your insurance Card

_____Valid driver's license or state ID

_____ A list of current medications

_____Your records and x-rays from your previous dentist, if possible

- **If able please give prior office a call to let them know we will be calling to get records so they have your verbal permission**

_____ Patient Photo

HOLDREGE
DENTAL ARTS

New Patient Information

First name: _____ Middle Initial: _____ Last name:_____
Preferred name of Nickname:_____
Date of birth:_____ Social Security number:_____
Address (Residential):_____
City:_____ State:_____ Zip:_____
Billing Address (if different than residential):_____
City:_____ State:_____ Zip:_____
Home phone:_____ Work phone:_____
Cell phone:_____ Email address:_____
I prefer to be contacted by(check all that apply): __phone call __email
Sex: ____Male ____Female
Marital Status: ____Married ____Single ____Divorced ____Widowed ____Other
Employer Name:_____
Emergency Contact:_____ Relationship:_____
Phone #:_____ Whom may we thank for referring you to our office?_____

Responsible Party Information (if other than patient)
Is the responsible party currently a patient in our office? ____Yes ____No
First name:_____ Middle Initial:_____ Last name:_____
Date of birth:_____ Social Security number:_____
Billing Address:_____
City:_____ State:_____ Zip:_____
Home phone:_____ Work phone:_____
Cell phone:_____ Email address:_____
Relationship to patient:_____

Dental Insurance Information (please provide your insurance cards)
Primary Dental Insurance
Name of the Subscriber:_____ Subscriber Birth Date:_____
Subscriber SSN:_____ Employer:_____
Insurance Company:_____ Address:_____
Address:_____ City:_____
City, State, Zip:_____ State:_____ Zip:_____
Secondary Dental Insurance
Name of the Subscriber:_____ Subscriber Birth Date:_____
Subscriber SSN:_____ Employer:_____
Insurance Company:_____ Address:_____
Address:_____ City:_____
City, State, Zip:_____ State:_____ Zip:_____

***By signing below, I authorize my insurance company to pay Holdrege Dental Arts, LLC all insurance benefits rendered. I authorize the use of this signature on all insurance submissions. I authorize Holdrege Dental Arts , LLC to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.**

Patient (or Guardian) Signature:_____ Date:_____

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DENTAL ARTS

Dental Information: Please mark (x) your responses to the following questions:

Date of your last dental exam? _____ What was done at that time? _____ _____ Date of last dental x-rays? _____ What is the reason for your dental visit today? _____ _____ _____ How do you feel about your smile? _____ _____ _____	Check any that apply: _____ I have had unfavorable past dental experience(s) _____ I have had complications from past dental treatment _____ I have had trouble getting numb _____ My teeth are sensitive to cold, hot, sweets, or pressure _____ My mouth is dry _____ My home water supply is well water or not fluorinated _____ I have had previous periodontal (gum) treatment _____ Reactions to local anesthetic _____ Previous orthodontic treatment (Braces) _____ I wear dentures or partials _____ I have sores or ulcers in my mouth _____ I am self-conscious about my smile _____ I have clicking, popping, or discomfort in the jaw _____ I clench/ grind my teeth _____ I am interested in whitening _____ I snore/ have been told I snore _____ Cost is prohibiting me from having my perfect smile _____ NONE OF THE ABOVE

Use this space to explain or let us know anything you would like to elaborate on in the above fields:

_____
_____
_____
_____
_____

Do you use any form of tobacco? _____Yes _____No

What Kind? _____

Do you use any form of controlled substances or recreational drugs? _____Yes _____No

Women: Are you pregnant? _____Yes _____No

How many weeks? _____

Circle one of the following in the statement:

I consider myself to be **PROACTIVE** or **REACTIVE** when it comes to my dental health.

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DENTAL ARTS

Medical Information: Please mark (x) your responses to the following questions:

Are you under the care of a physician? **____Yes ____No** Physician Name? _____ Clinic Name, City, and State? _____ _____ Are you in good health? **____Yes ____No** Date of last physical exam?_____	Please list all prescription and over the counter medications you are currently taking**: (Or provide a list)** _____ _____ _____ _____ _____ _____
Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? **____Yes ____No** Date: _____ Did your orthopedic surgeon recommend oral antibiotics be taken before future dental visits? **____Yes ____No**	Are you taking or scheduled to begin taking an antiresorptive agent (Like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia, Aredia, Zometa, XGEVA) for osteoporosis or Paget's disease, Multiple Myeloma, or Metastatic cancer? **____Yes ____No** **Please list your last injection or current regimen:** _____ _____
Please check all that apply to you: _____Artificial (prosthetic) heart valve _____Previous Infective Endocarditis _____Damaged valves in transplanted heart _____Congenital heart disease (CHD): _____Unrepaired, cyanotic CHD _____Repaired (Completely) in last 6 months _____Repaired CHD with residual defects **Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other from of CHD.**	**Allergies.** Are you allergic to or have you had a reaction to: _____Local Anesthetics? _____Penicillin or other antibiotics? _____Sulfa drugs? _____Codeine or other narcotics? _____Metals? _____Latex? _____None Please list any not previously mentioned: _____ _____
Please check all that apply or have applied to you: _____ Heart Attack _____Low Blood Pressure _____High Blood Pressure _____AIDS _____HIV Infection _____Pacemaker _____None	**Do you have any disease, condition, or problem not listed in health history that you think we should know about?** _____ _____ _____ _____

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DENTAL ARTS

Financial Policy:

Payment Options: Cash, Check, Money-Order, Health Savings Card or Credit Card

I hereby give Holdrege Dental Arts, L.L.C and all of its providers and staff consent to perform restorative and cosmetic dental treatments, services and elective procedures. I understand that this consent will cover all services rendered while at Holdrege Dental Arts.

As a condition of treatment by this office, financial arrangements must be made in advance. Our practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined prior to treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed, unless other arrangements are made or patient has insurance which covers emergency treatment.

Patients with a dental benefit plan are required to PAY THE ESTIMATED PATIENT RESPONSIBILITY PORTION on the day of service. If the patient wishes to know their exact responsibility, a pre-authorization can be sent to the insurance company for dental procedures that the patient will benefit from. (NOTE: Pre-authorizing treatment can delay treatment time.)

Patients with a dental benefit plan understand that all dental services are charged directly to the patient and that the patient is personally responsible for payment of all dental services not covered by patient's policy. Our office is happy to submit claims and assist in making collections from insurance companies. Any payment received will be applied to the patient's account and can be held as a credit on the account or can be refunded back to the patient in the form of a check if the patient has overpaid due to estimates generated by our dental software. However, our office cannot render services on the assumption that fees for service will be paid by the insurance company. The account balance ultimately remains the responsibility of the patient or responsible party.

Additionally, insurance estimates are based on information provided to us by your insurance carrier and in no way is a guarantee that services will be covered. Our front office staff is happy to provide you with assistance in communicating with your insurance company regarding any questions or conflicts you may have.

A service charge of 1.5% per month (18% per annum) on any unpaid balance will be charged on all accounts exceeding 90 days unless previously written financial arrangements are satisfied. Additionally, if any account is over 90 days past due, all patient/family cleanings or treatment will be canceled until the entire account balance is paid in full.

I understand that I am responsible for all debts incurred. If my account is assigned to a collection agency, I understand that I am responsible for all attorney fees, court costs or delinquency fees that may be incurred during the collection of my debt.

I am also aware Holdrege Dental Arts requires at least 24-hour business day notice to reschedule any appointment. If I fail or reschedule my appointment more than twice under the 24-hour time notice, I understand that in order to schedule any future appointments Holdrege Dental Arts will require a $50.00 deposit per each scheduled appointment.

By signing below, I understand the above information and agree with its contents.

Patient's Printed Name: _____

Name of Parent (or guardian), if patient is under 18:_____

Relationship to Patient: _____

Patient (or Guardian) Signature: _____

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HIPPA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form; therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with **OTHER THAN** healthcare providers.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

By signing below, I understand the above information and agree with its contents.

Patient's Printed Name: _____

Name of Parent (or guardian), if patient is under 18:_____

Relationship to Patient: _____

Patient (or Guardian) Signature: _____