TOOTHBUD DENTISTRY

Patient Information

Patient Name:_____

Date of Birth:_____ SS#:_____

Male / Female Married / Single / Minor / Other

Home:_____ Work:_____

Cell:_____

Email:_____(for email confirmation and office updates)

Address:_____

_____

Employer:_____

Responsible Party

Name:_____

Relationship:_____

Date of Birth:_____ SS#:_____

Male / Female Married / Single / Minor / Other

Home:_____ Work:_____

Cell:_____

Email:_____

Address:_____

_____

Employer:_____

Patient Emergency Contact

Name:_____

Relationship:_____

Home:_____ Work:_____

Cell:_____

Referral Information

Whom may we thank for referring you to our practice?
Circle all that apply

Patient (name):_____

Friend / Relative / Coworker / Facebook / Website

Doctor:_____

Other:_____

Primary Insurance

Name of Subscriber:_____

Date of Birth:_____

SS#:_____

Address:_____

_____

Employer:_____

Insurance Plan Name:_____

Group#:_____

Member ID#:_____

Secondary Insurance

Name of Subscriber:_____

Date of Birth:_____

SS#:_____

Address:_____

_____

Employer:_____

Insurance Plan Name:_____

Group#:_____

Member ID#:_____

Medical History

Allergies

___ Amoxicillin ___ Aspirin ___ Clindamycin

___ Codeine ___ Erythromycin ___ Latex

___ Penicillin ___ Sulfa

Other:_____

Medications

___ Antibiotics ___ Blood Pressure

___Heart Pill ___ Tranquilizers Thyroid

___ Arthritis ___ Blood Thinners

___ Hormones ___ Water Pill

___ Aspirin ___ Cortisone Steroids

___ Birth Control ___ Diabetic Pills

Current medications:_____

Have you ever had any of the following?

___ Aids ___ High Blood Pressure ___ Jaundice

___ Anemia ___ Artificial Joints ___ Kidney Disease

___ Asthma ___ Blood Disease ___ Liver Disease

___ Cancer ___ Mental Disorders ___ Nervous Disorders

___ Diabetes ___ Pacemaker ___ Radiation Treatment

___ Dizziness ___ Rheumatism ___ Respiratory Problems

___ Epilepsy ___ Hay Fever ___ Excessive Bleeding

___ Fainting ___ Tuberculosis ___ Rheumatic Fever

___ Glaucoma ___ Head Injuries ___ Sinus Problems

___ Growths ___ Heart Disease ___ Stomach Problems

___ Stroke ___ Tumors ___ Venereal Disease

___ Ulcers ___ Heart Murmur ___ Pregnancy (Due Date: ___/___/___)

When was your last cleaning?_____

Please Rate How Deep You Would Like Your Cleaning

1 2 3 4 5

Lighter Intensity **Heavier Intensity**

Consent

To the best of my knowledge, all of the proceeding information provided is correct. If I have any changes, I will inform the front desk staff and/or doctor at the next appointment without fail. I give those employed at Toothbud Dentistry permission to perform treatment on me or my child.

Signature:_____

Date:_____

Consent for Dental Treatment

I give Toothbud Dentistry permission to perform dental treatment on me and/or my child/children.

As the parent/legal guardian of _____, I do hereby authorize those employed at Toothbud Dentistry to perform dental treatment on the above named child and/or me, with the aid of the following items, if necessary:

_____ Mouth Prop: assists child in holding his or her mouth open

_____ Nitrous Oxide: commonly called "laughing gas", a mild sedative that is inhaled and reduces anxiety. Can cause mild nausea

I understand that this document remains in effect unless I request to make a change in the use of the mouth prop or nitrous oxide at which time I will need to sign a new "Consent for Dental Treatment" form.

Name:_____ Signature:_____ Date:_____

HIPAA Acknowledgement

I understand that by signing this agreement, I am allowing Toothbud Dentistry to use my protected health information and to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices, provided by HIPAA, before you decide whether or not to sign this consent. Our notice provides a description of our treatments, payment activities, and healthcare operation of the use and disclosure we may make of your protected health information, and of other important matters about your protected health information.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the address listed below. Please understand that the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:_____ Date:_____

Agreement for Testimonial

I give Toothbud Dentistry permission to post me and/or my child on social media if requested.

Yes No

Signature_____ Date_____

Cancellation Policy

At Toothbud Dentistry we understand your time is valuable. To make sure that we can provide everyone with the best and most prompt service we require **24 hours notice** for all cancellations. We understand that emergencies or unexpected obligations arise, but without proper notice we cannot schedule other patients at that time that need treatment. After 3 broken appointments we will charge your account a **$25 missed appointment fee**. We appreciate your attention to this matter and want to help in any way possible to avoid these fees.

Account Balance

We ask that all patients with private pay accounts pay their balance in full before receiving further treatment. Patients who have questions about their bill can ask the front desk and we can discuss payment plans etc. **Payment** is due **before** services rendered.

Signature_____ Date_____

Agreement to Pay: I, the undersigning, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court cost, if such be necessary.

Express Prior Consent to Contact Consumer by Cell Phone: You agree, in order for us to service your account or to collect monies you may owe, ToothBud Dentistry and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using and/or use of automatic dialing device, as applicable.

I have read this disclosure and agree that ToothBud Dentistry, its employees and/or agents may contact me as described above.

_____ _____

Responsible Party Signature Date