LANDMARK DENTAL GROUP

Whom may we thank for referring you? _____

PATIENT INFORMATION

Name: _____ Preferred Name: _____
Last First MI
Sex: ( ) Male ( ) Female

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Soc. Sec. #: _____-____-_____ Email Adress: _____

Home Phone: _____ Cell Phone: _____ Status: ( ) Single ( ) Married ( ) Child

DENTAL INSURANCE INFORMATION

Dental Insurance Company: ( ) HDS ( ) HMSA ( ) Other: _____ Subscriber ID #: _____

Group #: _____ Group Name: _____ Insurance Phone: _____

Subscriber Name: _____ Relationship to Patient: ( ) Self ( ) Spouse ( ) Child
Last First

Employer: _____

Subscriber Date of Birth: _____ Subscriber Soc. Sec. #: _____-____-_____

Is patient covered by additional insurance? ( ) Yes ( ) No If yes, what is the insurance company? _____

MEDICAL HISTORY

Physician's Name: _____ Phone Number: _____

Please circle *Yes* or *No* whether you have had any of the following:

Allergies/Hay Fever	Yes	No	Frequent Cough	Yes	No	Pacemaker	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Radiation Treatment	Yes	No
Arthritis	Yes	No	Heart Disorder *	Yes	No	Respiratory Problems	Yes	No
Artificial Joints *	Yes	No	Heart Murmur *	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valves *	Yes	No	Hepatitis	Yes	No	Sinus Problems	Yes	No
Asthma	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	HIV/AIDS	Yes	No	Surgical Shunt *	Yes	No
Chemotherapy	Yes	No	Kidney Problems	Yes	No	Thyroid Problems	Yes	No
Diabetes	Yes	No	Liver Problems	Yes	No	Tobacco Use	Yes	No
Epilepsy or Seizures	Yes	No	Mental Disorders	Yes	No	Tuberculosis	Yes	No
Fainting or Dizziness	Yes	No	Mitral Valve Prolapse *	Yes	No	Ulcers	Yes	No
Fever Blisters/Cold Sores	Yes	No	Osteoporosis	Yes	No	Venereal Disease	Yes	No

* This condition may require antibiotic premedication for certain dental procedures

Do you have any health problems that were not listed above or need further clarification? Circle ***Yes*** or ***No***
If yes, explain: _____

Are you currently under the care of a physician? Circle ***Yes*** or ***No***
If yes, explain: _____

Are you taking any medications or herbals? Circle ***Yes*** or ***No***
If yes, explain: _____

Are you allergic to any of the following?
( ) Latex ( ) Penicillin ( ) Aspirin ( ) Codeine ( ) Iodine ( ) Metal ( ) Other: _____

Women: Are you pregnant? Circle ***Yes*** or ***No*** Are you taking oral contraceptives? Circle ***Yes*** or ***No***

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used for the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical history, I will inform the dentist.

Signature: _____ ***Date:*** _____
Parent/Guardian if patient is under the age of 18

DENTAL QUESTIONNAIRE

Do your gums hurt or bleed?	Yes	No	Do you get headaches or migraines?	Yes	No
Do you feel your breath is offensive?	Yes	No	Do you get neck aches or stiff neck?	Yes	No
Do you brush your teeth regularly?	Yes	No	Do you wake up with sore teeth?	Yes	No
Do you floss your teeth regularly?	Yes	No	Do you wake up with a tired jaw?	Yes	No
Do you get food stuck in your teeth	Yes	No	Do you clench or grind your teeth?	Yes	No
Are your teeth sensitive?	Yes	No	If yes, when? Day / Night / Both		
Are you missing teeth?	Yes	No	Are you interested in orthodontic treatment?	Yes	No
Do you have an unpleasant taste in your mouth?	Yes	No	Are you happy with the appearance of your teeth?	Yes	No
Do you have popping/clicking in your jaw?	Yes	No	Do you snore?	Yes	No
Has your jaw ever locked?	Yes	No	Have you ever been diagnosed with sleep apnea?	Yes	No
Do you have difficulty opening wide or yawning?	Yes	No	Do you have a sinus problem?	Yes	No
Do you have TMJ problems?	Yes	No	Have you ever had a sleep study done?	Yes	No
Do you have regular pain in your jaw?	Yes	No			

1. I have a
   { } low
   { } moderate
   { } high fear
   of going to the dentist.

2. I would say my main concerns with my dental health are:
   _____
   _____

3. I left my previous dental office due to:
   _____
   _____

Please circle services interested in and would like information on:

INVISALIGN	LASER PROCEDURES
ZOOM WHITENING	SMILE DESIGN
SAME DAY CROWNS	TMJ
PERIODONTAL (GUM) TREATMENT	

HIPAA Notice of Privacy Practices

I understand that I have a right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize *Landmark Dental Group* to use and disclose my protected health information for:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but are not required to agree to these requested restrictions. However, if chosen to agree, I am bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occured prior to the date I revoke this consent is not affected.

I have had full opprtunity to read and consider the contents of this Notice of Privacy Practice. I understand that by signing this consent form, I am giving my consent to *Landmark Dental Group*'s use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ ***Date:*** _____

Parent/Guardian if patient is under the age of 18

FINANCIAL AGREEMENT

DENTAL INSURANCE

As a courtesy, we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- Your insurance policy is a contract between you, your employer and the insurance company. We are **not** a party to that contract. Our relationship is with you and not your insurance company.

- Although we may estimate your insurance benefits, we are not responsible for their accuracy. Our treatment coordinators will provide an estimate based off of your insurance plan as a courtesy to you. Knowledge of benefit amounts, limitations, exclusions, waiting periods, etc. is entirely **your** responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of your estimate.

- **All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment.** Not all the services we provide are covered benefits. Fees for noncovered services, along with deductibles and copayments, are due at the time of treatment.

PAYMENT POLICY

We accept cash, personal checks, debit cards and all major credit cards.

- There will be a $25.00 charge for any returned checks.

We also accept Care Credit, subject to credit approval.

- Convenient monthly payment plans that allows you to pay overtime in 6 or 12 months with no interest or down payment.
- No extra fees or pre-payment penalties. Balance must be paid off on Care Credit's terms and agreements.

We require payments prior to the beginning of your treatment.

- For treatment requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $1,000.00 or more, a 50% deposit is required to secure your initial treatment apointment.

An account with an unpaid balance past 90 days will be sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt; an interest rate of 21% of the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

APPOINTMENT POLICY

Appointments not kept or changed less than 48 hours notice are considered broken. Broken appointments prevent others from receiving the dental care they deserve. Please be considerate to the reserved time we have for you and inform us in advance if you need to cancel or reschedule your appointment.

To reschedule or cancel an appointment, you must notify us at least 48 hours in advance to avoid a missed appointment fee of $50.00 per hour. We reserve the time to terminate professional treatment of any patient when scheduled appointments are not kept.

I have read and understood this document in its entirety, outlining financial policies including dental insurance, payment policy and appointment policy. I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I authorize the dentist 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. By signing below, I agree to abide by the policies listed above.

Signature: _____ ***Date:*** _____

Parent/Guardian if patient is under the age of 18