

Name of Patient _____



Patient Information

| | | | | | | |
|-------------------------|----------|----------------|---|------------------------|-------------------------------|---------------------------------|
| Patient's First Name | | Middle Initial | Last Name (as it appears on insurance card or ID) | | <input type="checkbox"/> Male | |
| Preferred Name (if any) | | Date of Birth | | Social Security Number | | <input type="checkbox"/> Female |
| Patient's Address | | | City | State | Zip | |
| Home Phone | Cellular | | Email Address | | | |
| Referred By | | | | | | |

Patient Employer/School Information

| | | | | | | |
|-------------------------|------------|--|-----------------------|-------|-----|--|
| Employer/School | Occupation | | Employer/School Phone | | | |
| Employer/School Address | | | City | State | Zip | |

Emergency Contact Information

| | | |
|------------------------|-------------------------|---------------------|
| Emergency Contact Name | Emergency Contact Phone | Relation to Patient |
|------------------------|-------------------------|---------------------|

Billing and Insurance Information

| | | | | | |
|--|--------------|---------------------------|------------------------|-----|--|
| Insurance Company | | Plan | | | |
| Plan Number | Group Number | Insured's Employer/School | | | |
| Insured's Name (as it appears on Insurance card or ID) | | Relation to Patient | Insured's phone number | | |
| Insured's Address | | City | State | Zip | |
| Insured's Social Security Number | | Insured's Birthdate | | | |

Financial Responsible Party

| | | | | | |
|--------------------------------------|--|---------------------|-------|-----|--|
| Billing Name (If other than patient) | | Relation to Patient | Phone | | |
| Address | | City | State | Zip | |



Name of Patient _____



Medical History - Your Physician Name/Phone Number: Dr.

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

- Alcoholism
- Allergies
- Anemia
- Anxiety Disorder
- Arthritis
- Asthma
- AIDS/HIV
- Bleeding Disorder
- Blood Disease
- Blood Transfusion
- Bowel Disorder
- Cancer
- Diabetes
- Depression
- Eating Disorder
- Epilepsy
- Hay fever
- Heart Disease
- Heart Problems
- Hepatitis – A, B, or C
- High Blood Pressure
- High Cholesterol
- Joint Disorder
- Kidney Disorder
- Liver Disorder
- Lung Disease
- Lupus
- Measles
- Migraines
- Osteoporosis
- Pacemaker
- Rheumatic Fever
- Sinus Problems
- Skin Disorder
- Stroke
- Stomach Ulcer
- Substance abuse
- Thyroid Disorder
- Tuberculosis
- Venereal Disease

Comments: _____

Current Medications

Are you taking any blood thinner? Yes No

If yes, please name it: _____

Are you taking **Osteoporosis** Medication? Yes No

If yes, please name it: _____

Hospitalizations & Surgeries? Yes No

If yes, please list Date & Reason. _____

Any Allergy? Yes No

| | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Local Anesthesia |

Other _____

Are you taking any medication? Yes No

If yes, please list medication. _____

Have you ever Smoked? Yes No # of years _____

Do you smoke now? Yes No # packs/day _____

Do you use recreational drugs? Yes No Types? _____

How much alcohol do you drink per week? _____

Women Only

Are you pregnant? Yes No

Are you breastfeeding? Yes No

Birth Control? Yes No

Dental History

Reason for visit Today : _____

When was your last dental exam? _____

When were your last dental x-rays taken? _____

How often do you brush? # per day _____

How often do you floss? _____

Do you grind or clench your teeth? Yes No

If yes, do you wear Night/Day Guards? Yes No

Have you ever had orthodontic (braces) treatment? Yes No

Have you ever had periodontal (gum) treatment? Yes No

Do you have any of the following?

- Bad breath
- Bleeding gums
- Blisters on mouth
- Broken fillings
- Clicking Jaw
- Dentures
- Dry Mouth
- Difficulty Chewing
- Ear Pain
- Jaw Pain
- Loose Teeth
- Mouth Plain
- Mouth Sores
- Partial
- Sensitivity to Cold
- Sensitivity to Heat
- Sensitivity to Sweets
- Sensitivity to Pressure
- Swollen Gums

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

Signature of Patient, parent or guardian _____

Print Name (if other than patient) _____

Date _____

Dentist's Signature _____

Date _____



Name of Patient _____



Financial Policy

We are committed to providing the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing up-to-date information and educational tools so you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service while minimizing our administrative costs.

All charges incurred are your responsibility regardless of your insurance coverage. As your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company.

As a courtesy, we will process your dental claims with your primary insurance provider. In order for our office to file your insurance claim, you must provide complete and accurate dental insurance information. Any changes in dental insurance must be provided in order to process your claims.

Although benefits may be verified at the time of service, it is not a guarantee that your insurance company will cover our services. Please understand that financial responsibility for dental services rests between you and your dental plan. While we are pleased to be of service by filing your dental insurance for you, we are not responsible for any limitations in your plan coverage. If your plan denies payment for any reason or has not paid your claim within 60 days, you will be responsible for payment.

Our office accepts cash, checks, all major credit cards and Care Credit.

There is \$25.00 fee for all returned checks.

Appointments missed without a 24-hour cancellation notice may incur a \$25.00 fee. This fee must be paid in order to schedule any future appointments.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with a positive experience in our office.

By signing below, I confirm that I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any service performed by Bobcat Dental.

Patient Signature

/ Print Name (If different from patient) /

Date



Name of Patient _____



Authorization for Communication

With my initials below, Bobcat Dental may use and disclose protected health information about me to carry out appointment, treatment and payment. Please refer to Bobcat Dental's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practice at any time.

With My Consent

Bobcat Dental may also send mail or email to my home in reference to any items that assist the practice in carrying out treatment, payment, and health care operations such as appointment reminders, billing information, insurance items, newsletters, contests, and promotions.

Please check the appropriate box below indicating your method of communication: (mark all that apply)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

If you mark any phone, please check the appropriate box below:

- Leave a message on voice mail with detailed information
- Leave a message on voice mail with a call-back number only

If you mark home phone, please check the appropriate box below:

- Leave a message on answering machine and may leave a message with whomever answers my home phone
- Do not leave a message on answering machine or speak to anyone in my household other than myself.

I understand that any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment, and health care operations. I understand and have been provided a Notice of Patient Privacy handout that provides a more complete description of information uses and disclosures. A photocopy or fax of the consent is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

Signature of Patient or Parents/Guardian

Date

Print Name of Signed person (if patient is under the age of 18 years)



Name of Patient _____



Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that this organization from time to time and that I may request a current copy at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Please list family members or other persons, if any, whom we may inform about your general dental condition and your diagnosis (including appointment, treatment, & financial account).

I, (Patient) _____, received Notice of Privacy Practices, and do hereby consent to have information regarding my appointment, treatment & financial account discussed with/and or released to:

I, (Parent/Guardian) _____, received Notice of Privacy Practices, and do hereby consent to have information regarding patient's appointment, treatment & financial account discussed with/and or released to:

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Signature of Patient or Parents/ Guardian

Date

