Welcome! We are pleased to welcome you to our practice. Please fill out the following forms as completely as possible.

Patient Name*:* _____**Preferred Name**: _____
Last First MI

SS # _____ **Date of Birth**_____ □ **Male** □ **Female** □ **Married**□ **Single**□ **Widowed** □ **Partner**

E-mail address:_____(This is used to email patients aboutappointments or special offers.)

Home address:_____

StreetApartment # **CityStateZip Code**

Phone Numbers: Home_____ **Work**_____ **Cell**_____

Employer Name: _____

Dental Insurance: _____ **ID#** _____ **Group#**_____

Subscribers Name _____**Date of Birth** _____

Emergency Contact: _____**Phone** _____

Can we thank someone for referring you?

Family member _____

Coworker _____

Friend _____

Or did you find us on your own?

___Our website

___ Internet
___ Insurance website

___ Other_____

********Date of last dental visit**_____

Smile topics of interest □ **Whitening** □ **Veneers** □**Crowns**□ **INVISALIGN**□ **Night guard**

Do you have or do any of the following?

□**Abscess**□ **Food gets trapped**□**Bad breath**

□ **Suck thumb**□**Bleeding gums** □ **Blisters in mouth** □**Cold sores**□**Clenching/grinding teeth**□ **Dry mouth**

□ **Gag easily**□**Pain in jaw** □**Sensitive gumsSensitive to**: □**Hot** □**Cold**□**Sweet**

 **Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.**
Please answer the following medical history questions as correctly as possible. Thank you!

Have you ever had or currently have any of the following? Please check those that apply.

□AIDS/HIV □Head Injuries □Radiation Treatment

□Anemia □Heart Disease □Respiratory Problems

□Arthritis □Heart Murmur □Sinus Problems

□Artificial Joints □ Hepatitis A / B / C □Stomach Problems

□Asthma □High Blood Pressure □Stroke

□Cancer □Kidney Disease □Tuberculosis

□Chemical Dependencies □Liver Disease□Transplant/Prostheses

□Diabetes □Mental Disorders_____□Ulcers

□Epilepsy □Pacemaker □Drug Allergies_____

□Excessive Bleeding □Sensitivity to latex products

Do you have any conditions that are not listed above that we should know about?

_____

Are you currently under the care of a Physician? _____ Name of Physician._____

Physician's phone number_____

Medications you are currently taking_____

Has your doctor told you to take antibiotic medication before dental treatment?□ Yes □ No

Do you take a bone-building drug □Yes □ No

Do you currently use tobacco? □ Yes □ Nolf so, how long? _____ Do you want to quit? □ Yes □ No

Have you ever had any complications or allergic reactions following dental treatment? □ Yes □ No

If yes, please explain:_____

<u>WOMEN ONLY:</u>Are you pregnant?□ Yes □ No□Maybe Are you nursing?□ Yes □ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever haveany change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

PATIENT CONSENT FOR SERVICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the **Health Insurance Portability and Accountability Act of 1996 (HIPPA).** I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

Obtaining payment from third party payers (Ex: insurance company).

Upon my request I maysecure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

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 health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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

I have read and agree to the terms in this CONSENT FOR SERVICES

_____ Date: _____

Signature of patient

OFFICE FINANCIAL POLICY

I affirm that the information I have given on this form is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize my insurance benefits be paid directly to **Agape Dental Studio** and I understand that I am responsible for the payment of deductibles, co-payments, and any balances not covered by my insurance. I further understand that fees for professional services rendered are payable in full within 30 days. A service charge of 1% per month will be added to all account balances for 60 days old; this is an annual rate of 12%. I understand that if my account becomes delinquent, I may be referred to a third party for collection. If this should be turned over to collections, processing fee 35%-50% will applied to the balance. I also understand that future dental services may be limited for all persons under my account until my account is current. I also authorize **Agape Dental Studio** to release any information required to process my claims. I understand that payment is due at the time of service.

I have read and agree to the terms in this OFFICE FINANCIAL POLICY.

_____ Date: _____

Signature of patient

To All Agape Dental Studio Patients

Due to a recent increase in the amount of last minute **cancelled or "no show"** appointments, we are implementing the following new policies. **We understand that unanticipated events happen occasionally in everyone's life, the late train or last minute meetings etc. But in our desire to be effective and fair to all our patients, the following policies are in effect at AGAPE DENTAL STUDIO.**

Scheduled Appointments- When a patient schedules an appointment they are responsible for that date and time. Our office provides many ways to remind patients of their appointments as a **COURTESY**. We send text or email reminders and also call patients. Patients are ultimately responsible to confirm their scheduled appointments. If there is no confirmation your appointment may be given to someone else to avoid an unproductive schedule in our office.

24 Hours Advance Notice- If you are unable to make your **CONFIRMED** scheduled appointment we do ask you to give the office **24 hours' notice**. This allows the opportunity for someone else to schedule an appointment at this time. If the **CONFIRMED** appointment is not cancelled within **24 hours a $50.00 cancellation fee** will be applied to your account.

No Shows- Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a **NO SHOW** and a **$50.00 missed appointment fee** will be applied to your account.

Late Arrivals- If you arrive late, your appointment may be shortened in order to accommodate others whose appointment follows yours. Depending upon how late you arrive, your Dr. will then determine if there is enough time remaining to start your treatment. Out of respect and consideration to your Dr. and staff and other patients, please plan accordingly and please be on time.

We value all of you as patients and look forward to seeing you at your next appointment here at **AGAPE DENTAL STUDIO!**

Signature: _____Date: _____

Your Dental Insurance

AGAPE DENTAL STUDIO would like to welcome you to our practice. Our entire staff is here to provide you with dedicated and efficient customer service. Working with your dental insurance is very detailed and requires much attention. Please understand that your insurance company does not guarantee payment for any services. As a courtesy, we will make every effort to file insurance claims and calculate co-payments based upon the estimate of benefits we receive them (at any time we can provide you this information).

It is very important that you are familiar with your dental benefits. You are responsible for your dental insurance policy. Often your insurance company will send you reading materials explaining what your dental benefits are and their policies and stipulations; If they have not you can always request this information. This will help reduce the risk of your insurance company not paying for your services. Any procedures that are not covered by your insurance or have been denied is your responsibility. Any correspondence your insurance company sends to us, they will also send to you; so it is important that you do not disregard any information that they send to you. We encourage you to keep this information for you records.

We will provide you with any assistance you need in order to receive your maximum benefits, but it is important for you to know what your benefits are and how your insurance works. Our first priority is your overall health and any treatment you require. We look forward to you being a patient at our office and strive for you satisfaction and oral health.

Sincerely,

Your AGAPE DENTAL STUDIO Staff

I have read and understand the above statement about My Dental Insurance.

Signature: _____Date: _____