Patient Information and Health History

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential, subject to applicable laws. Please note that you will be asked some questions baout your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Information

Name:		Home Phone:	Cell Phone:
Address:	City:	State:	Zip:
Email Address:	Date of Birth:	Height:	Weight:
Occupation:	SSN:		
Emergency Contact:	Relationship:		Contact Number:

Dental Insurance Information

Subscriber's Name:	Subscriber's Date of Birth:	
Subscriber's SSN:	Relationship to Patient:	Cell Phone:
Insurance Company Name:	Member ID Number:	Group Number:
Employer's Name:	Employer's Phone Number:	

If you are completing this form for another person, please state your name and relationship:

Name: Relationship:

Do you have any of the following: **Please Circle:**

Active Tuberculosis	Yes	No
Been exposed to anyone with tuberculosis	Yes	No
Persistent cough greater than a 3 week duration	Yes	No
Cough that produces blood	Yes	No

If you answered yes to any of the above, please stop and return this form to the receptionist.

Dental Information

	Please Circle:	
Do your gums bleed when you brush or floss	Yes	No
Are your teeth sensitive to cold, hot sweets or pressure?	Yes	No
Does food or floss catch between your teeth?	Yes	No
Is your mouth dry?	Yes	No
Have you had any periodontal (gum) treatments?	Yes	No
Have you ever had orthodontic (braces) treatment?	Yes	No
Have you had any problems associated with previoys dental treatment?	Yes	No
Is your home water supply fluoridated?	Yes	No
Do you drink bottled or filered water?	Yes	No
If yes, how often? Circle one: Daily / Weekly / Occasionally	Yes	No
Are you currently experiencing dental pain or discomfort?	Yes	No
Do you have earaches or neck pain?	Yes	No
Do you have any clicking, popping or discomfort in the jaw?	Yes	No
Do you brux or grind your teeth?	Yes	No
Do you have sores or ulcers in your mouth?	Yes	No
Do you wear dentures or partials?	Yes	No
Do you participate in active recreational activities?	Yes	No
Have you ever had a serious injury to your head or mouth?	Yes	No

Health History

Have you had a serious illness, operation or been hospitalized in the past 5 years? Y N
If yes, ______________________

Are you taking or have you recently taken any prescription or over the counter medicines? If yes, please list all medications (including natural or herbal supplements): __________ Y N

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JOINT REPLACMENT Have you had an orthopedic total joint (hip, knee, elbow, finger) Y N

Are you taking or scheduled to start taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteporosis or Paget's disease? Y N

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain or hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? If Yes, Y N

Do you use controlled substances (drugs)? Y N
Do you use tobacco (smoking, snuff, chews, bidis)? Y N
Do you drink alcoholic beverages? If yes, how often ______________ Y N
Have you had any alcoholic beverages within the last 24 hours? Y N

ALLERGIES Are you allergic to or have you had a reaction to:

Allergy		Allergy	
Local anesthetics	Y N	Latex (Rubber)	Y N
Aspirin	Y N	Iodine	Y N
Barbiturates, sedatives or Sleeping Pills	Y N	Hay Fever / Seasonal	Y N
Codein or other Narcotics	Y N	Animals	Y N
Penicillin or other Antibiotic	Y N	Food	Y N
Sulfa Drugs	Y N		Y N

WOMEN ONLY

Question	
Are you Pregnant? If yes, # of Weeks:____	Y N
Are you Nursing?	Y N
Taking Birth Control Pills?	Y N
Hormonal Replacement?	Y N

Please circle if you have any of the following conditions:

Condition		Condition	
Congenital heart disease (CHD)	Y N	Artificial (prosthetic) heart valve	Y N
Unrepaired, cynotic CHD	Y N	Previous infective endocarditis	Y N
Repaired (complete) in last 6 mos	Y N	Damaged valves in transplanted heart	Y N

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

Condition		Condition		Condition	
Cardio Vascular Disease	Y N	Autoimmune Disease	Y N	Hepatitis, Jaundice or Liver Disease	Y N
Heart Condition If yes, specify ________	Y N	Rheumatoid Arthritis	Y N		
		Lupus	Y N	Epilepsy	Y N
Pacemaker	Y N	Asthma	Y N	Fainting Spells or Seizures	Y N
Chest Pain upon Exertion	Y N	Bronchitis	Y N	Neurological Disorders If yes, specify__________	Y N
Low Blood Pressure	Y N	Emphysema	Y N		
High Blood Pressure	Y N	Sinus Trouble	Y N	Sleep Disorder	Y N
Rheumatic Fever	Y N	Tuberculosis	Y N	Mental Health Disorder If yes, specify __________	Y N
Abnormal Bleeding/Disorder	Y N	Cancer/Chemo/Radiation Tx	Y N		
Anemia	Y N	Chronic Pain	Y N	Recurrent Infections Type of infection ________	Y N
Aids or HIV Infection	Y N	Diabetes Type 1 or 2	Y N		
Sexually Transmitted Disease	Y N	Eating Disorder	Y N	Kidney Problems	Y N
Arthritis	Y N	Malnutrition	Y N	Osteoporosis	Y N
Thyroid Problems	Y N	Gastrointestinal Disease	Y N	Severe Headaches or Migraines	Y N
Stroke	Y N	G.F. Reflux or Persistant Heartburn	Y N		
Glaucoma	Y N			Severe or Rapid Weight Loss	Y N
Excessive Urination	Y N	Ulcers	Y N		

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Y N
If yes, Name of Physician ______________________ Number __________

Do you have any other disease, condition, or problem no listed above that you think I should know about? Y N
If yes, please explain______________________

I certify that I have read and understand the above and that the information given on this form is accurate.

Signature of Patient / Legal Guardian ______________________ Date __________

Orchard Dental Care
FINANCIAL AGREEMENT

PAYMENT FOR SERVICES, INCLUDING DEDUCTIBLES AND COPAYMENTS, ARE DUE AT TIME OF SERVICE, unless other arrangements have been made PRIOR to treatment. Payments may be made using cash, check or credit cards. Any arrangements for third-party financing must be made PRIOR to starting treatment. At this time, Orchard Dental Care partners with Care Credit for third-party financing.

Orchard Dental Care accepts most PPO dental benefit plans. We are happy to submit the claims necessary to see that you receive your dental benefits. The dental benefit contract (your insurance plan) is an agreement between you and your insurance company. You are ultimately responsible for all charges incurred at our office. We can only make ESTIMATES regarding your insurance benefits based on the information provided by you and/or your insurance company. We also cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed. If you are in doubt of what your plan covers, please request a pre-authorization of services.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Your plan may exclude, have limitations, and/or have clauses which prevent your plan from covering standard dental procedures. Orchard Dental Care cannot be held responsible for any limitations and/or clauses within your insurance policy. Your dental plan is also intended to cover some but not all dental care costs, and not all services will be covered by your plan. You are responsible for payment of ALL services regardless of the payable benefit.

In the event your insurance company does not pay as much as expected, or sets different fees for procedures higher than estimated, the remaining balance (determined by your plan) is due and payable immediately by you, the patient. Additionally, if we have not received payment from your insurance company within 60 days following your services, YOU are responsible for paying the entire amount due, and encouraged to seek reimbursement from your insurance company directly. In the event that your account is ever over-paid, you will be given a credit on your account to be used for future dental care, or a refund will be issued.

Surprise Billing - Effective 1/1/22, all CO-DOI health insurance plans are covered under HB 1174, which states that all emergency and non-emergency services received by an in-network facility, but by an out of network provider are protected from surprise or balance billing in cases where the patient was not notified prior to being seen by the out of network provider. Orchard Dental Care does our best to verify benefits prior to each patients' visit and will notify patients when made aware of an out-of-network status.

ASSIGNMENT OF INSURANCE BENEFITS- I/We hereby assign directly to Orchard Dental Care dental benefits otherwise payable to me/us. I/We hereby authorize the release of any information relating to any claims. I/We understand that I/We are financially responsible for charges not paid by this assignment.

RETURNED CHECKS OR NSF ACH DEBITS- In the event your check is returned unpaid due to insufficient funds, you authorize your check to be electronically redeposited for the face amount of the check. Recovery fees, as applicable by state law, will be assessed on all returned checks and **may** be collected from your checking account, and/or billed directly to you. By presenting your check for payment for your transaction, you are acknowledging your acceptance of our Check Acceptance Policy. In the event your account does not have the authorized funds to be debited you will be charged a minimum of $25 per NSF transaction. This fee applies to both checks and ACH Debits.

DELINQUENT ACCOUNTS- All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS- In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fees for procedures at the time of service. An additional fee of 40% of your total patient portion will be applied to cover collection costs. If your account is turned over to collections, you and your family will be dismissed as patients.

CANCELLATION/NO SHOW/TARDINESS- WE REQUIRE A 24 HR. NOTICE FOR ALL CANCELED APPOINTMENTS- Individuals who fail to show for an appointment or call to reschedule within 24 hours of their

scheduled appointment are subject to a cancellation fee of $50.00 per hour based on the length of the missed appointment time. We do understand that situations arise, (such as a sick child) and we are very sympathetic to those situations. A TARDINESS of more than 15 minutes for an appointment WILL be rescheduled and may be subject to a missed appointment fee.

Patient initials ______

CHANGES TO THIS FORM WILL NOT BE HONORED!

OUR OFFICE IS AN AMALGAM FREE OFFICE, which means we do not do any silver fillings. All of our fillings are done with resin material that is matched to the color of your teeth.

Most insurance companies will pay as though an amalgam filling was done because they are less expensive. For example, if the resin filling costs $100, the insurance company may pay for that same filling done as an amalgam (silver) filling which may be $80 they would then pay their percentage based on that lower fee. It is your responsibility as the patient to pay the difference. We do our best to estimate what your costs will be. We are always glad to answer any questions you may have.

ADULT SUPERVISION IS REQUIRED FOR ALL CHILDREN 13 and younger and all children who have medical conditions who are 17 and younger. Please check with the doctor or office staff regarding your child's health status with our office. If your child is left unattended, treatment will be stopped immediately and you will be charged for the cost of the appointment. If your child is over 14 years old and you must leave, you are required to provide a cell phone number and an additional emergency number. Please note; insurance does not allow us to bill them for treatment that was not completed due to patient non-compliance.

CELL PHONES MUST BE TURNED OFF while in the treatment areas. If we are unable to complete treatment due to cell phone use, you are still responsible for the cost of the appointment. Please note; insurance does not allow us to bill them for treatment that was not completed due to patient non-compliance.

DUPLICATION FEE- There may be a $25 duplication fee per family to copy all x-rays.

WE RESERVE THE RIGHT to update our office policies at any time. As a patient you agree to abide by the policies set forth in our office.

I HAVE COMPLETELY READ AND UNDERSTAND THE CONTENTS OF THIS AGREEMENT. I AGREE TO COMPLY WITH ALL OFFICE POLICIES.

Patient Name: ______

Responsible Party Signature: ______ Date: ______

CHANGES TO THIS FORM WILL NOT BE HONORED!

Orchard Dental Care
Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I hereby give my consent for Orchard Dental Care to:

1. Use and disclose protected health information about me to other healthcare providers who may be involved in my treatment directly or indirectly.
2. Obtain payment from third-party payors (i.e. insurance, financing companies, etc.)

With this consent, Orchard Dental Care may contact me through the following means: telephone, voicemail (if necessary), email and/or mail in reference to any item that will assist the practice in carrying out my patient care, such as appointment reminders, insurance items, account balances, patient statements and information pertaining to my clinical care.

In addition to the allowable disclosures described in the Notice of Privacy Practices, please specifically identify any individuals whom you authorize disclosure of your protected health information. Without indicating by checking in the box to each individual question, personal protected information cannot be shared with anyone unless otherwise allowed by HIPAA rules. Please check all that apply:

- ☐ Spouse only
- ☐ Any member of my immediate family (i.e. spouse, children, siblings, etc)
- ☐ Any member of my extended family (i.e. parents, grandchildren, etc)
- ☐ Other (please write the name of the individual): ______________________________

I acknowledge that I have the right to review the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Orchard Dental Care has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my personal protected information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: ______________________________ Signature: ______________________________

Please Note: Orchard Dental Care uses Dentrix as our dental software. Families with insurance coverage that extends to spouses and dependents cannot be separated from the subscriber within our system. As a result, financial information is combined for the family. Should you have any concerns regarding this practice, please speak to the front desk right away.