

## PATIENT INFORMATION

Date:		Marrie	ed 🔄 Single 🔄
Male 🗌 Female 🗌 Non-Binary 🗌 P	refer not to disclose 🗌 P	refer to self-describe	
Last Name:	First N	lame:	Middle:
Preferred Name:	DOB:	SS	#:
Address:	City:	State:	Zip:
Home #:	Cell #:	Work #:	
Email Address:			
Name of nearest relative not living with you:		Phone #:	
How did you hear about our office? 🗌 Patient Name: 🗌 Other: Other:		:	
	RESPONSIBLE PART	<u>Y INFORMATION</u>	
Last Name:	First N	lame:	Middle:
Preferred Name:	DOB: _	SS	#:
Address:	City:	State: _	Zip:
Home #:	Cell #:	Work #:	
Employer:	Address:		
	DENTAL INSURANC	E INFORMATION	
<u>PRIMARY</u>		<u>SECOI</u>	NDARY
Insured's Name:		Insured's Name:	
Insured's DOB:	Insured's DOB:		
Insured's Phone #:			
Insured's SS#:		Insured's SS#:	
Insurance Address:		Insurance Address:	
Insurance Phone #:		Insurance Phone #:	
Insured's Employer:		Insured's Employer:	

#### **DENTAL INFORMATION**

Do you gums bleed when you brus	h? 🗌 YES 🗌 NG	D Are you	r teeth sensitive to heat/c	old? 🗌 YES 🗌 NO
Are your teeth sensitive to pressur	e? 🗌 YES 🗌 NG	D Do you l	have a fear of the dentist	PYES NO
Do you grind or clench your teeth?		D Have yo	u had your teeth bleache	d? 🗌 YES 🗌 NO
How do you feel about the appear	ance of your teeth	n? Love them 🗌 accept the	em 🗌 want to change the	em 🗌
How do you feel about the appear				
Date of last Examination:		What was done a	t that time?	
Are you interested in using Nitrous	Oxide (Laughing	gas)? [] YES [] NO		
	Δ	MEDICAL HISTORY INFORM	<u>ATION</u>	
Current Dental Problem(s):		Discor	nfort at this time? 🗌 YES	5 🗌 NO
Have you been a patient in the hos	pital in the past 2	years? YES NO Ur	nder Physician Care? 🗌 Y	ES 🗌 NO
Physician Name:		Phone #: _		
Are you taking any medications?	YES 🗌 NO	Please list all medications	:	
· · · · · · · · · · · · · · · · · · ·				
Are you sensitive or allergic to any	medication or an	esthetics?		
Indicate which of the following you	have had or have	e at the present (Check "ve	s" or "no" for each)	
Heart disease, attack or failure			YES NO STDS	🗌 YES 🗌 NO
Heart Murmur		High Blood Pressure		sclerosis YES NO
Mitral Valve Prolapse		Artificial Heart Valve		acemaker YES NO
Heart Surgery		Rheumatic Fever	YES NO Diabete	
Rheumatism		Cortisone Medicine		ddiction YES NO
Stroke		Low Blood Pressure	YES NO Blood D	
Hypoglycemia		Kidney Trouble	YES NO Artificia	
Ulcers		Thyroid Problems	YES NO Glaucor	
Cancer/Tumors		Emphysema		
Asthma		Allergies, Hives or Hay Fever		
		Chemotherapy		
Radiation Therapy Breathing Problems		Shortness of Breath	YES NO Hep A, YES NO Pain in	
Congenital Heart Disease		HIV Positive/AIDS		
-		-		
Anemia/Sickle Cell		Bruise Easily		
Epilepsy/Seizures		0. 7 1	YES NO Jaundic	sness YES NO
Developmentally Disabled				
Do your ankles swell during the da				
Are you on a special diet? YES If yes, please list:		ave or nave you had any di	sease, condition, or prob	iem not listed? [] YES [] NO
Use tobacco products? YES			ol products? VES I	NO If yes, How often?
Do you vape? YES NO If yes				
	, now onen!			
FOR WOMEN ONLY:	/16			
Are you pregnant? YES NO	(If yes, what mon	th?) Nursing?		rth Control 🔄 YES 📋 NO
I understand the above information	on is necessary to	provide me with dental ca	re in a safe and efficient	manner. I have answered all
questions truthfully and to the be		-		
PATIENT SIGNATURE:			_DATE:	
PATIENT OR RESPONSIBLE PARTY:				
Medical Review: Reviewed by:	Date:	Medical History	Update by Patient: Initial	s: Date:
				s: Date:
	Date:		Update by Patient: Initial	

## FINANCIAL AND INSURANCE POLICIES

Thank you for choosing us as your dental care provider. We are anxious to serve you and are committed to providing the best care possible. Payment is due at time of treatment. In order to make your dental care financially comfortable, we offer the following financial options.

## Payment in Full Courtesy (for fees totaling over \$300.00).

A prepayment courtesy of 10% will be subtracted from total patient obligation (for patients without insurance) if the patient obligation is Paid in Full.

## Outside financing (for fees totaling over \$500.00)

We use different finance companies that specialize exclusively in helping the patient with larger dental cases. With fast approval over the telephone and no interest for 6 to 18 month if gualified, your payments can be much lower than those available through our office. There is no prepayment penalty and terms can be extended as far as 60 months. We will assist you in contacting them from our office.

### **On Account Accrued Payments**

Payments may also be made to your account prior to having treatment completed. Once treatment has been pre-paid in full, treatment may begin.

## **Cancellation Policy**

Henderson Family Dental requires 48 hours notice is given in any event of cancellation of scheduled visit. A \$50.00 fee will be assigned to your account if failure to comply.

### Pay As You Go

We accept Cash, Visa, MasterCard, Discover, American Express, Money Order, Personal Checks

### **INSURANCE**

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. At the time of service we will ask you for your estimated co-payment. Please understand that this is only an estimate, and is based upon the information available to us.

Insurance benefit coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office.

# The financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office. We will assist you in any way we can. Once your insurance carrier has

paid the claim, any difference will be due upon receipt of our statement. If for any reason we have not received your insurance carrier's payment 90 days after the claim was submitted, the remaining balance will be due and payable by you and subject to 21% APR. Should the account be referred to an attorney or collection agency, all cost of collection, including up to 50% collection fee, as well as court costs and a reasonable attorney fee will be the patient's responsibility.

Patient's Signature \_\_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Parent or Responsible Party Relationship to Patient

## WE ARE PLEASED TO HAVE YOU AS OUR PATIENT

#### CONSENT TO PROCEED

I authorize Dr. Schwartz and/or such associates or assistants as he may designate to preform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle stimulation, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions. This office retains the healthcare records of patients as part of regularly maintained records for five years after their receipt or production. After this period records may be disposed.

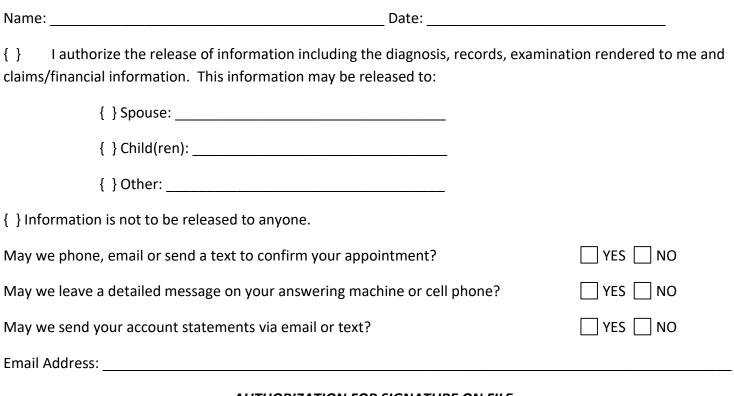
After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate TMJ disorder. Gums and surrounding tissues may be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand that the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs that is prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with standard dental preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:		
Signature:	Date:	
(Patient, legal guardian or authorized agent of patient)		
Witness:	Date:	



# AUTHORIZATION FOR SIGNATURE ON FILE

l,	and/or	Hereby authorize the office of
Henderson Family Den	tal to affix my name to any and all claims c	or documents as related to any and all health
benefits due me and m	y dependents through my Insurance.	

I hereby authorize payment of dental benefits, otherwise payable to me, directly to the office listed above. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating the claim. This "Authorization" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

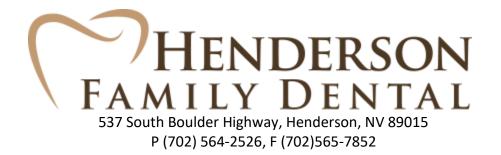
## ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Henderson Family Dental's Notice of Privacy Practices, which has an effective date of 01/05/2023 which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices any time, and that I will be provided a copy of any updated version. And that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have completed the above dental release, been provided with a copy of the Notice of Privacy Practices, and I have read and agree to the Authorization for signature on file:

Patient Name:	
Signature:	Date:
(Patient, legal guardian or authorized agent of patient)	
Witness:	Date:



## ORAL CANCER SCREENING CONSENT FORM

Our office strives to bring its patients state-of-the art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID screening device into our office. The OralID screening will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (Pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like OralID dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during conventional oral cancer screening, the chances of survival are dramatically reduced.

Who is at Risk?

- Age 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID.

How much does the screening cost?

• \$40 unless covered by patient insurance

YES, I request that your staff perform a screening with the OralID.	
Signature:	Date:
NO, I prefer to not have this screening at this visit.	
Signature:	Date: