VAUGHN FAMILY DENTAL

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions or need assistance, don't hesitate to ask.

PRINT ALL - Patient name: _____ Date of birth: _____ Gender _____

Cell: _____ Home: _____ **E-mail**: _____

If no cell phone, enter Home phone

Home address: _____ In case of emergency call: _____

City: _____ State: _____ Zip: _____ SS #: _____

Billing: (if different): Name: _____ Address: _____

City: _____ State: _____ Zip: _____

How did you hear about us? Family/Friend; Facebook; Web search; Insurance List; Other: _____

PRIMARY DENTAL Insurance Information: Subscriber: _____ DOB: _____

SS #: _____ Relationship to patient: Self Spouse Child ID #: _____

circle one

Insurance Company _____ Insurance Phone: _____

if different than above:

Group #: _____ Employer: _____ Subscriber Phone _____

SECONDARY DENTAL Insurance Information: Subscriber: _____ DOB: _____

SS #: _____ Relationship to patient: Self Spouse Child ID #: _____

circle one

Insurance Company _____ Insurance Phone: _____

if different than above:

Group #: _____ Employer: _____ Subscriber Phone _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?		
Have you had problems with previous dental treatment?		
Do you gag easily?		
Do you wear dentures?		
Does food catch between your teeth?		
Do you have difficulty in chewing your food?		
Do you chew on only one side of your mouth?		
Do you avoid brushing any part of your mouth because of pain?		
Do your gums bleed easily?		
Do your gums feel swollen or tender?		
Have you ever noticed slow-healing sores in or about your mouth?		
Are your teeth sensitive?		
Do you feel twinges of pain when your teeth come in contact with		
Hot foods or liquids?		
Cold foods or liquids?		
Sours?		
Sweets?		
Do you take fluoride supplements?		
Are you dissatisfied with the appearance of your teeth?		
Do you prefer to save your teeth?		

	Yes	No
When was your last dental visit? DATE: D _____		
Do you want complete dental care?		
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others?		
Do you clench or grind your jaws frequently?		
Do your jaws ever feel tired?		
Does your jaw get stuck so that you can't open freely?		
Does it hurt when you chew or open wide to take a bite?		
Do you have earaches or pain in front of the ears?		
Do you take medications or pills for pain or discomfort (pain relievers; muscle relaxers; anti depressants)?		
Does jaw pain or discomfort affect your appetite sleep, daily routine, or other activities?		
Do you find jaw pain or discomfort extremely frustrating or depressing?		
Do you have any jaw symptoms or headaches upon awaking in the morning?		
Do you have a temporomandibular (jaw) disorder (TMD)?		
Do you have pain in the face, cheeks, jaws, joints, throat or temples?		
Are you unable to open your mouth as far as you want?		
Are you aware of an uncomfortable bite?		
Have you had a blow to the jaw (trauma)?		
Are you a habitual gum chewer or pipe smoker?		

VAUGHN FAMILY DENTAL

MEDICAL HEALTH HISTORY:

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

	Yes	No
Heart Problems		
Chest pain		
Shortness of breath		
Blood pressure problem		
Heart murmur		
Heart valve problem		
Taking heart medication		
Rheumatic fever		
Pacemaker		
Artificial heart valve		
Blood Problems		
Easy bruising		
Frequent nosebleeds		
Abnormal bleeding		
Blood disease (anemia)		
Ever require a blood transfusion?		
Allergy Problems		
Hay fever		
Sinus problems		
Skin rashes		
Taking allergy medication		
Asthma		
Intestinal Problems		
Ulcers		
Weight gain or loss		
Special diet		
Constipation Diarrhea		
Kidney or bladder problems		
Bone or Joint Problems		
Arthritis		
Back or neck pain		
Joint replacement (e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy		
Stroke(s)		
Frequent or severe headaches		
Thyroid problems		
Persistent cough or swollen glands		
Premedication's required by physician Rx		
Cancer/Tumor		

Are you allergic, or have you reacted adversely, to any of the following?

Local anesthetics ("Novocain")		
Penicillin or other antibiotics		
Sulfa drugs		
Barbiturates, sedatives, or sleeping pills		
Aspirin, Acetaminophen, or ibuprofen		
Codeine, Demerol, or other narcotics		
Reaction to metals		
Latex or rubber dam		

Other

	Yes	No
Diabetes – Are you Diabetic?		
Urinate more than 6 times a day		
Thirsty or mouth is dry much of the time.		
Family history of diabetes		
Tuberculosis or other respiratory disease		
Do you drink alcohol?		
If so, how much?		
Do you smoke?		
If so, how much? _____		
Hepatitis, jaundice, or liver trouble		
Herpes or another STD		
HIV-positive/AIDS		
Glaucoma		
Do you wear contact lenses?		
History of head injury?		
Epilepsy or other neurological disease?		
History of alcohol or drug abuse?		
Do you have any disease, condition or problem not listed previously that you feel we should know about?		
If so, please describe: _____		

During the past 12 months have you taken any of the following?

Antibiotics or sulfa drugs		
Anticoagulants (e.g. Coumadin)		
High blood pressure medicine		
Tranquilizers		
Insulin, Orinase, or similar drug		
Aspirin		
Digitalis or drugs for heart trouble		
Nitroglycerin		
Cortisone (steroids)		
Natural remedies		
Nonprescription drug/supplements		

Other

Women

Are you taking contraceptives or other hormones?		
Are you pregnant?		
If so, expected delivery date: _____		
Are you nursing?		
Have you reached menopause?		
If so, do you have any symptoms?		

Notes:

X

Signature or Parent/Guardian Signature **Date**

Vaughn Family Dental

Change, Cancellation and/or
Missed Appointment Policy – 48 Hour Notice
Effective January 1, 2019

Our goal at Vaughn Family Dental is to provide you with convenient, accessible, high quality dental care. You will be treated with respect and respect of your time. We ask you arrive on time for your appointment and contact us 48 hours in advance of a scheduled appointment if you require a change/cancellation of your appointed time. This enables us to schedule emergency appointments with respect for all confirmed appointments and/or fill your change/cancellation appointment. We will make every effort to provide you with appointment reminders by email and text message; 1 month; 1 week and 2 days in advance. Please confirm your appointment with these reminders. We understand, life happens, and you may contact our office during regular business hours Monday – Thursday 8 am to 5 pm and we will reschedule your appointment to the next available appointment.

Fees for Missed, Changed or Cancelled Appointments

A "missed appointment" is an occurrence where a patient does not arrive for a scheduled appointment without 48-hour notice and will be treated as a cancelled appointment without 48-hour notice.

In an effort to prevent increasing our fees, only patients that miss, cancel or change appointments with less than 48 hours' advance notice of a scheduled appointment will be charged a $35 fee for all type of appointments.

I acknowledge that I have read and understand the above policy regarding fees for missed, changed or cancelled appointments. Payment of $35 is due at the time of cancellation or rescheduling of each appointment, for each family member.

Sign: _____ Date: _____

Print Name: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

for updated guidelines effective August 2016

Name:_____ **Date of Birth**:_____

Dependent: _____ Dependent: _____

Dependent: _____ Dependent: _____

Dependent: _____ Dependent: _____

TO THE PATIENT/GUARDIAN—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice of Privacy Practices is available in the office. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed on the Notice of Privacy Practices. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you/dependents or to continue treatment if you revoke this Consent.

SIGNATURES

I, (Print) _____**, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.**

X Signature:_____ **Date:**_____

If this Consent is signed by a personal representative on behalf of the patient/dependent, complete the following:

Personal Representative's Name:_____ Relationship to Patient:_____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

X Signature:_____ **Date**: _____

If this Consent is signed by a personal representative on behalf of the patient/dependent, complete the following:

Personal Representative's Name:_____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

Financial Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CREDIT CARDS, AND DEBIT CARDS. WE ALSO OFFER **CARE CREDIT** WHICH IS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at the time of service. If you are unable to pay at the time service is scheduled, be sure to contact us 7 days in advance of your appointment.

Minor Patients

The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

(cont)

Financial Policy (cont.)

Payment Plans

Vaughn Family Dentistry has partnered with Care Credit, a patient financing company, to offer our patients 0% interest financing for 6 or 12 months with approval. No other payment plans are available.

Billing

All accounts which have not paid the estimated portion of their bill at the time of service will incur a $3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 1.5% finance charge with equals an 18% per annum rate. There is also a $30 returned check fee.

Refunds

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

Collections

Any account that has not received payment in full within **60 days** may be handed over to a collection agency that will pursue the responsible party for payment of all fees for treatment; collection fees; attorney fees; court costs and other fees associated with recovery of fees for treatment provided. This may negatively impact your credit history and limit the treatment you can receive at our office. Bankruptcy filed against your account, will result in your termination of your account and treatment for all patients under this account.

Thank you for understanding of our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.

_____

Signature Date

_____

Print Name