Valley Dental

1111 Main Street
Hope Valley RI
401-539-6007

PATIENT INFORMATION **Date**_____

Name_____ Age_____ Date of Birth _____/_____/_____
Home Address _____
City_____ State _____ Zip_____
Home Phone (_____) _____-_____ Cell # (_____) _____-_____
E-Mail Address _____@_____
Appointment Confirmation Preference: Chose one _____Home _____Text _____E-Mail
Emergency Contact
Name_____Relationship_____Phone#_____

PRIMARY DENTAL INSURANCE

Name of Insurance_____
ID Number_____Group #_____
Policy Holder_____
Policy holder's date of birth _____/_____/_____Relationship to patient_____
Employer_____Address_____

SECONDARY DENTAL INSURANCE

Name of Insurance_____
ID Number_____Group #_____
Policy holder's date of birth_____/_____/_____Relationship to patient_____
Employer_____Address_____

DENTAL HISTORY

Previous Dentist?_____ Address_____
Last date of cleaning? ___/___/___X-ray's?___/___/___X-ray Type?_____
How do you feel about dental visits? ( )Comfortable ( ) Uncomfortable ( ) Very Uncomfortable
Do you have any present dental complaints?_____

MEDICAL HISTORY

All of the questions asked are essential in arriving at a diagnosis and proper treatment plan. All questions must be answered. If any question is not understood, it should be discussed with the doctor. If a medical condition exists, and is not related to any question on this form it must be reported to the doctor.

Physician _____Phone ( )_____-_____
Date of last complete physical examination _____/_____/_____ Results_____
Are you in good health? ( ) Yes ( ) No Height _____ Weight_____
Are you presently under the care of a medical specialist? ( ) Yes ( ) No
Physician_____Phone ( ) _____-_____
If yes, please explain_____
_____
Have you ever had surgery? ( ) Yes ( ) No
If yes please explain _____Date_____
_____Date_____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD/OR PRESENTLY HAVE:

__Aids/HIV positive
__Allergies
__Anemia
__Arthritis
__Artificial Heart Valve
__Artificial Joints (hip, knee)
__Asthma
__Bleeding Problem
__Blood Transfusion
__Bruise Easily
__Chemotherapy
__Cortisone/Steroid Treatment
__Chest Pain
__Diabetes
__Drug Addition
__Epilepsy
__Fever Blisters
__Glaucoma
__Hay Fever
__Hearing Disorder
__Heart Disease or Attack
__Heart Murmur
__Heart Pacemaker
__Hepatitis
__High Blood Pressure
__Kidney Trouble
__Liver Disease
__Mitral Valve Prolapse
__Psychiatric Treatment
__Radiation Treatment
__Respiratory Problems
__Rheumatic Fever
__Stroke
__Thyroid Disease
__Tuberculosis (T.B.)
__Tumor Malignancy
__Ulcers
__Venereal Disease

Do you have history of endocarditis? __Yes __No If yes when?_____

Are you taken any prescribed medication, over the counter medications or drugs?

Medication Dosage Reason

_____
_____
_____
_____
_____
_____

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

__Aspirin __Local Anesthetic __Erythromycin __Nickel/other metals __Nitrous Oxide
__Codeine __Sulfa __Penicillin __Latex __Other? please list_____
_____

Do you smoke? __Yes __No If so how much?_____

Are you __Pregnant __Nursing __Taking Birth Control ? Due date? ___/___/___

Do you need antibiotics pre-medication prior to dental treatment? __Yes __No
Physician prescribing pre-medication ?_____

Do you have any other health concerns? if so please
explain:_____

_____
_____
_____
_____
_____

OFFICE POLICIES

Please be sure to read each policy thoroughly, your signature is required at each area indicated by the symbol X.

1) **OFFICE ACCEPTANCE AND CONSENT**: I understand that the information provided on this form is essential to determine my dental needs and the provisions of dental treatment. I understand that if ANY CHANGES occurs in my health, I am to report it to the dental office. I have read and understand each question and have answered all of them truthfully, and to the best of my ability. I authorize the Doctor to perform diagnostic procedures including dental radiographs, examination, dental prophylaxis, topical fluoride application and/or any treatment as may be necessary for my dental care.

X_____

Patient / Legal Guardian Signature **Date**

2) **INSURANCE AUTHORIZATION AND PAYMENT/FINANCIAL POLICIES**: I authorize my insurance company to pay Valley Dental directly, and I understand that my dental care insurance carrier may pay less than the actual bill for services. It is the insurance holders responsibility to know their coverage and benefits. I understand that I am financially responsible for payments in full on all accounts.

If you have dental insurance, your dental claims will be processed as follows:

* In Network - If the dentist is a participating provider with your insurance, you will be billed pursuant to the terms of your dentist's agreement with your insurer.

* Out of Network - If the dentist is NOT a participating (or in network) provider with your insurance plan, we will submit claims to your insurer, AS A COURTESY. If your insurance carrier will not accept assignment of benefits to you dentist, YOU ARE RESPONSIBLE for any and all costs incurred, not covered and paid by your insurance company.

If you have any questions related to your insurance coverage, we encourage you to contact your insurance company directly. It is your responsibility to NOTIFY THE OFFICE IMMEDIATELY if there are any changes to your insurance plan or any lapse in coverage. If for any reason your account is turned over to a collection agency or collection attorney, the responsible party agrees to pay ALL FEES CHARGED by the agency or attorney, IN ADDITION TO the fees owed for services provided by the office.

X_____

Patient / Legal Guardian Signature **Date**

3) **MISSED APPOINTMENT POLICY:** I understand the office requires at least a 24 HOURS NOTICE for all appointment cancellations. If I am unable to provide 24 hours notice, I will be billed $30.00 charge for scheduled appointment time.

X_____

Patient / Legal Guardian Signature **Date**

4) **HIPAA ACKNOWLEDGEMENT AND CONSENT:** I have been provided with a copy of the HIPPA policy and notice of privacy practices. I have read and understand its contents. I do hereby consent and acknowledge my agreement to the terms set forth in the office's notice of the privacy practices and any subsequent changes in office policy. I understand that this consent shall remain from this time forward.

X_____

Patient / Legal Guardian Signature **Date**

5) **CAREGIVER'S AUTHORIZATION AFFIDAVIT:** The purpose of this affidavit is to provide **YOUR LEGAL AUTHORIZATION** for another adult to bring your child to routine dental appointments and make decisions on your behalf, in the event that you are unable to bring your child. Should you withdraw or amend this authorization, you must do so **IN PERSON** at our dental office We prefer that, as the parent / legal guardian, you accompany your child to all dental visits. we reserve the right to decline treatment of your child in any situation where the office feels your presence is essential.

PLEASE NOTE: IF YOU ARE A COURT APPOINTED LEGAL GUARDIAN, COPIES OF COURT DOCUMENTS STATING THAT YOUR ARE THE LEGAL GUARDIAN OF THE CHILD ARE NECESSARY FOR OUR RECORDS PRIOR TO TREATMENT.

YOUR SIGNATURE BELOW INDICATES THAT:

*You are authorizing our dental office to discuss treatment of your child with any adult accompanying your child to his / her appointment (s).

*You will be responsible for relaying office policies and procedures to any adult accompanying your child, and assuring that they comply.

* You understand and agree to allow the adult accompanying your child to make decisions on your behalf, as outlined in this affidavit.

*You are responsible for making payment arrangement **ON THE DATE OF TREATMENT**.

*You will notify the dental office I**N PERSON** should you wish to amend or withdraw authorization.

Any adult accompanying your child must be **AT LEAST 18 YEARS OF AGE** and is expected to **REMAIN IN THE OFFICE** with your child while treatment is rendered.

The accompanying adult will be able to provide consent on your behalf for and changes in treatment plan **(YOU WILL BE RESPONSIBLE FOR ANY ADDITIONAL FEES INCURRED)**, consent to behavior management techniques (inhaled nitrous oxide restraint, act.) receiving post-operative instructions and relaying them clearly and correctly to you, communicating to you expectations and / or any information relative to your child's present or future dental needs.

X_____

Patient / Legal Guardian **Date**