

Anthem Hills Dental
PATIENT INFORMATION

Patient Name _____ DOB _____ Date _____
Address _____ City _____ ST _____ Zip _____
Preferred Contact # _____ Home # _____ Cell # _____
E-mail _____ SSN _____ Marital Status: S M Other
Employer _____ Type of Work _____ Work # _____
Business Address _____ City _____ ST _____ Zip _____
Emergency Contact _____ Phone # _____ Relationship _____

Please answer the following questions if the Patient is a minor:

Name of Parent or Guardian (P or G) responsible for the account _____
Relationship to child _____ Preferred Contact # _____
(P or G) SSN _____ (P or G) DOB _____
(P or G) Employer _____ (P or G) Work # _____
Billing Address _____ City _____ ST _____ Zip _____

Please let us know how you heard about us:

- | | |
|--|---|
| <input type="checkbox"/> Friend (who) _____ | <input type="checkbox"/> Signage |
| <input type="checkbox"/> Relative (who) _____ | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Insurance Preferred Provider List | <input type="checkbox"/> Walk-in/Drive By |
| <input type="checkbox"/> Advertising or Direct Mailer | <input type="checkbox"/> Other _____ |

Insurance Information

Primary Dental Insurance:

Subscriber Name _____ SSN _____ DOB _____
Employer _____ Employer phone # _____
Employer Address _____ City _____ ST _____ Zip _____
Insurance Company _____ Insurance phone # _____
Subscriber/Member ID # _____ Group or Policy # _____

Secondary Dental Insurance:

Subscriber Name _____ SSN _____ DOB _____
Employer _____ Employer phone # _____
Employer Address _____ City _____ ST _____ Zip _____
Insurance Company _____ Insurance phone # _____
Subscriber/Member ID # _____ Group or Policy # _____

I attest that the above information is true and accurate to the best of my knowledge.

Patient Signature _____ Print _____ Date _____
or
(P or G) Signature _____ Print _____ Date _____

Anthem Hills Dental DENTAL HISTORY

Name _____ Date of Birth _____

Previous Dentist _____ How Long _____

What is your immediate dental concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

- | | | |
|--|-----|----|
| Are you happy with the appearance of your teeth?..... | Yes | No |
| Have you had any unfavorable dental experiences?..... | Yes | No |
| Do you have any dental fears?..... | Yes | No |
| Problems with the effectiveness or bad reactions to dental anesthetic?.. | Yes | No |
| Have you had orthodontic treatment (braces)?..... | Yes | No |
| Periodontal (gum) treatment?..... | Yes | No |
| Bleeding Gums?..... | Yes | No |
| Avoid brushing any part of your mouth?..... | Yes | No |
| Is any part of your mouth sensitive to temperature?..... | Yes | No |
| Do you have any sore teeth?..... | Yes | No |
| Any burning sensations in your mouth?..... | Yes | No |
| Difficulty swallowing?..... | Yes | No |
| An unpleasant taste or odor in your mouth?..... | Yes | No |
| Dry mouth, throat, and or eyes?..... | Yes | No |
| Jaw problems (temporomandibular joint, TMJ)..... | Yes | No |
| Difficulty opening your mouth widely?..... | Yes | No |
| Stiff neck muscles?..... | Yes | No |
| Awaken with an awareness of your teeth or jaws?..... | Yes | No |
| Do you get tension headaches?..... | Yes | No |
| Clench or grind your teeth?..... | Yes | No |
| Does your jaw click or pop?..... | Yes | No |
| Have you lost any permanent teeth?..... | Yes | No |

On a scale of 1 to 10 with 10 being the highest, please rate the following:

How important is your dental health?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

If I could change something about my smile, I would...

- have whiter teeth.....
- have straighter teeth.....
- close spaces in my teeth.....
- repair chipped teeth.....
- replace missing teeth.....
- replace old crowns that don't match.....
- replace metal fillings with tooth colored ones.....

Anthem Hills Dental
MEDICAL HISTORY

Patient Name _____ Date _____

If you are currently under the care of a physician please answer the following:

Physician Name _____ Phone # _____
Address _____ City _____ ST _____ Zip _____
For what reason? _____ Date of Last Visit _____

Please Circle the appropriate response for each question.

- | | |
|--|---|
| 1.) Do you have allergies or sensitivity to latex?..... Yes No | 11.) Do you have asthma?..... Yes No |
| 2.) Do you have allergies or sensitivity to metals?.... Yes No | 12.) Have you ever had seizures or epilepsy?..... Yes No |
| 3.) Are you pregnant or suspect you could be?..... Yes No | 13.) Have you ever tested positive for HIV?..... Yes No |
| 4.) Have you had surgery in the past 10 years? Yes No | If yes, when? _____ |
| If yes, for what? _____ | 14.) Have you ever tested positive for Hepatitis?..... Yes No |
| 5.) Have you ever had to pre-medicate for a | If yes, when? _____ |
| dental appointment?..... Yes No | What type? _____ |
| If yes, please circle the following reason: | Outcome? _____ |
| Heart Disease Mitral Valve Prolapse | 15.) Do you or have you ever had Tuberculosis?..... Yes No |
| Pacemaker Rheumatic Fever | If yes, when? _____ |
| Heart Murmur Artificial Heart Valves | 16.) Do you use any tobacco products?..... Yes No |
| Other _____ | Smoke Chew Snuff |
| 6.) Do you have high blood pressure?..... Yes No | If yes, how much? _____ |
| 7.) Have you been seriously ill in the last 10 years?. Yes No | 17.) Do you have any other medical problems we |
| If yes, with what? _____ | should know about?..... Yes No |
| 8.) Do you have artificial joints or prosthesis?..... Yes No | If yes, what? _____ |
| 9.) Do you bleed excessively when cut or injured?.... Yes No | 18.) How long has it been since: |
| 10.) Are you Diabetic?..... Yes No | Your last dental exam? _____ |
| If yes, what type? _____ | Your last professional cleaning? _____ |

Please list all OTC and prescription meds you take:

Are you allergic to any medications? Please list:

Dr Notes:

I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature _____ Print _____ Date _____
(P or G) Signature _____ Print _____ Date _____

Anthem Hills Dental
WRITTEN FINANCIAL POLICY

PAYMENT METHODS AND ARRANGEMENTS: Thank you for choosing Anthem Hills Dental. Our primary mission is to provide the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible by offering several payment options. We accept cash, check, Visa, MasterCard, American Express, or Discover Card. We also offer Care Credit No Interest* Patient Payment Plans** and other third party finance plans that allow you to pay over time with convenient, low monthly payments. We also offer in house payment plans directly through Anthem Hills Dental.

Anthem Hills Dental requires payment for treatment, deductibles or co-pays, prior to the completion of your treatment, unless specific payment arrangements have been made. We accept payment in thirds for treatment under \$1000.00. For treatment over \$1000.00, payment arrangements must be made prior to starting treatment. If you choose to discontinue care before treatment is complete, a refund will be determined upon review of your case and is at the discretion of Anthem Hills Dental.

We offer a 5% courtesy accounting adjustment to cash patients who pay in full at the start of treatment.

We also offer a 5% senior citizen courtesy.

FINANCIAL AGREEMENTS: I further understand and accept that the responsibility for payment for dental services, therapeutics, or devices provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other financial arrangements have been made. I understand that financial agreements may be made prior to the work being started. I agree and promise to keep my commitments for these financial arrangements. I understand that if my account becomes 30 days delinquent, that Anthem Hills Dental may accrue interest at the rate of 18% per annum, beginning the first day of the delinquency. I also understand that if my account becomes more than 90 days delinquent it may be assigned to a third party collection agency. I understand that upon assignment of the account to a third party collection agency that an additional mark up of 35% will be added to the amount that I owe. I understand and agree to the adding of this collection fee. I understand and agree to the accrual of interest at 1.5% if my account becomes 30 days delinquent. I agree to pay Anthem Hills Dental for the services provided and interest if the account becomes 30 days delinquent. I also agree to any and all collection fees added to my remaining balance if it is 90 days delinquent and forwarded to a third party collection agency.

Anthem Hills Dental Charges \$25.00 for returned checks.

APPOINTMENTS: A fee of \$50.00 will be charged for patients who No Show or cancel an appointment more than one time in a calendar year without 24 hour notice. This charge is based on time reserved for your appointment. Once an appointment is made, please remember that this time has been reserved exclusively for you.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want.

PATIENT _____ DATE _____

PARENT OR GUARDIAN _____ DATE _____
(if patient is under the age of 18)

WITNESS _____ DATE _____

Anthem Hills Dental
CONSENT FOR DENTAL TREATMENT

HIPAA: The Department of Health and Human Services has established a "Privacy Rule" to help assure that personal health care information is protected. This rule was also created in order to provide a standard for almost all health care providers to obtain their patients consent for use and disclosure of health information about the patient in order to carry out treatment, payment, or health care options. As our patient we want to inform you that we respect the privacy of your health care records and will do all we can to secure the privacy of that information. When it is appropriate and necessary, we provide the minimum information about treatment, payment, or health care operations, in order to provide you the very best treatment for your interests. We also support your full access to your medical records. We may have indirect treatment relationships with you (such as laboratories), and may have to disclose personal health information for the purpose of treatment, payment, or other health care operations. You may refuse to consent to the use or disclosure of your personal health care information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). If you choose now to give consent, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this previously signed consent. You also have the right to review our privacy notice, to request restrictions, and to revoke your consent in writing after you have received this notice.

CONSENT: The undersigned hereby authorizes Anthem Hills Dental to take radiographs, study models, photographs, perform or order tests, or any other diagnostic aids deemed necessary or appropriate by Anthem Hills Dental in order to make a thorough diagnosis of the oral and physical condition of the patient. I also authorize Anthem Hills Dental to perform any and all forms of treatment medications, and/or therapy that may be indicated in connection with treating the disease conditions. I further authorize and consent that Anthem Hills Dental may choose and employ such assistance as they deem fit. I understand that the use of anesthetic agents embodies certain risks, which I accept if I choose to use anesthesia. I will not hold Anthem Hills Dental responsible for any omission I might have made in completing the medical history portion of these forms. I understand that there are no guarantees or warranties of any kind stated or implied by Dr. Wilson or any team member, in reference to any treatment that they may render.

INSURANCE: In order to avoid misunderstandings that may occur regarding dental insurance, we wish our patients to know that all professional services are rendered to you directly and all fees are ultimately your responsibility if the insurance company does not pay. The patient or guardian is personally responsible for payment of these fees. For patients with dental insurance, we are happy to work with your insurance carrier to maximize your benefits and directly bill them for reimbursement for your treatment. Your estimated portion of the treatment and any applicable deductibles will be collected at the start of treatment, unless specific payment arrangements have been made ahead of time. We will prepare necessary forms or reports, submit them for you with required x-rays and respond to reasonable requests for further information from the insurance companies in order to obtain the benefits from your insurance company or union plan. I consent and authorize Anthem Hills Dental to release any and all information about my dental condition and treatments to my insurance company as may be required to obtain benefits from them. I also authorize payment directly to Anthem Hills Dental of any benefits otherwise payable to me from my insurance company or dental benefit plan. However, if Anthem Hills Dental does not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits from your insurance carrier. WE DO NOT render our services on the basis that the insurance companies will pay all of our fees. Dental insurance is not similar to medical insurance and fees vary by different insurance companies. If you do not have insurance, and so desire, financial arrangements may be made prior to the work being commenced.

I acknowledge receipt of the Consent for Dental Treatment and the Written Financial Policy. I agree to all of the above conditions as set forth and so declare by my signature below. (A photocopy shall be as valid as the original)

PATIENT _____ DATE _____

PARENT OR GUARDIAN _____ DATE _____
(if patient is under the age of 18)

WITNESS _____ DATE _____