NewLeaf DENTAL CARE

Patient Information:

First Name:_____ Last Name:_____

Date of Birth:_____ SS#_____

Cell Phone #_____ Home #_____ Work #_____

Address: _____

In case of emergency who should we contact? Name: _____

Phone #_____ Relation:_____

Responsible Party Information (if different from above)

First Name:_____ Last Name:_____

Date of Birth:_____ SS#_____

Cell Phone #_____ Home #_____ Work #_____

Address: _____

If there is anyone you wish to have access to your information, account, treatment needs or make appointments for you we need your permission in writing if you are over the age of 18. Please indicate below anyone you would like to have access to your patient information.

I, _____, give permission for New Leaf Dental Care to release my dental information to the below listed person(s).

First Name:_____ Last Name:_____

Relation: _____ Date of Birth:_____

By signing below you acknowledge that the information listed is accurate and true.

Responsible Party Signature: _____ Date:_____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care service we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Emily Young.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient Signature **Date**

Patient or legally authorized individual signature

Relationship
(parent, legal guardian, personal representative

NewLeaf DENTAL CARE

Financial Policy Acknowledgement

We are committed to providing you with the best possible care. Our fees reflect our professional commitment to excellence. For the convenience of our patients, we offer the following methods of payments.

Patients Without Insurance

Cash patients will receive a 5% discount at time of service with cash, check or credit card.

Cash senior patients (age 65) will receive an additional 5% totaling 10% discount.

Patients that have insurance are asked to pay the estimated portion at the time of treatment.

We offer monthly payment plans thru Care Credit. Apply online @CareCredit.com or we can help you apply in the office.
There are many options including no interest for up to 12 months depending on the amount financed. Ask for details and pamphlet.

Missed Appointments

We ask that you give us 24-hour notice to cancel an appointment reserved for you.

There will be a $50 per appointment cancellation fee charged if the appointment is failed or a 24-hour notice is not given. Any subsequent cancellation after that will be doubled.

Patients that fail to keep an appointment twice may be put on a same day only status or may not be rescheduled at all.

Our time must be used as efficiently as possible to be able to accommodate all of our patient needs.

Dental Insurance

Because we are not a party to your insurance contract, we can only **estimate** what your insurance may cover for a given procedure. We are not linked to the insurance company therefore our computer printouts are only estimating your portion. The exact amount of payment isn't known until a claim is paid. There is never a guarantee of payment including pre-authorizations.

I understand the above and agree that I am responsible for the entire amount of treatment that I elect to have done, regardless of what my insurance covers. I agree that any balance remaining is subject to a minimum $5.00 monthly finance charge or 1.5% of the total account balance. My signature below is my consent to the fee.

Signature _____ Date _____

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

Social Security Number: _____ **Email:**_____

If you have had dental treatment recommended in the past and did not proceed, what factors prevented you from scheduling? (Here or elsewhere)

__Cost
__Fear of Pain
__No time
__No insurance
__Didn't hurt/Didn't think I needed treatment
__Other (please explain) _____

HEALTH HISTORY

Physician's Name: _____ Date of last medical exam: _____

Check (✓) if you have or had any of the following:

__AIDS
__Anemia
__Arthritis
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Back Problems
__Cancer, Tumor, Malignancy
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cortisone Treatments
__Cough up Blood
__Congenital Heart Disorder
__Cough, Persistent
__Diabetes
__Epilepsy, Seizures
__Fainting, Dizziness
__Glaucoma
__Headaches
__Heart Attack
__Heart Murmur
__Hepatitis, Type _____
__Herpes
__High Blood Pressure
__HIV Positive
__Hospitalization
__Immune Disorder
__Jaundice
__Kidney Disease
__Liver Disease
__Major Surgery, Type _____
__Mitral Valve Prolapse
__Nervous problems
__Pacemaker
__Pain in Jaw Joint
__Prolonged Bleeding Disorder
__Psychiatric Care
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Scarlet Fever
__Shortness of Breath
__Sinus Trouble
__Skin Rash
__Stroke
__Swelling of Feet or Ankles
__Taking Fen-Phen or Redux?
__Thyroid Problems
__Tobacco Habit, Type _____ How much _____
__Tonsillitis, Lung Disease
__Tuberculosis
__Ulcer
__Venereal Disease
__Are You Pregnant? Due Date _____

Medications

List medications you are currently taking:
(Include oral contraceptives and alternative medicines)

_____
_____

Allergies

__Aspirin
__Barbiturates
__Codeine
__Latex
__Local Anesthetic
__Penicillin
__Sulfa
__Other:_____

Pre-medication

Do you normally take an antibiotic prior to dental treatment? ___ yes ___ no

The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of New Leaf Dental Care responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Authorization

I authorize my insurance company to pay New Leaf Dental Care all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid by my insurance or not.

Signature _____ Date _____

I consent to the use of my pictures for educational purposes and publication by New Leaf Dental Care.

Signature _____ Date: _____

Payment is due in full at time of treatment unless prior arrangements have been made.