OELWEIN DENTAL ASSOCIATES

Patient Info

Patient's Name_____

Date of Birth_____Age_____SSN_____[ ] minor [ ]single [ ]married [ ]widowed

Name of Spouse (if applicable)_____

Home Address_____

Home Phone (___)_____Cell Phone (___)_____

Email address_____

May we contact you with text messages to confirm your appointments? Yes No

Name of Employer_____

How did you find out about us? (please circle one) Friend/Relative Our Sign Internet Phone Book

Emergency Contact:_____Phone:_____

Are you covered by dental insurance? **Yes** **No**

If no... How do you intend to pay? **CASH** **Credit Card** **Care Credit**

YOUR DENTAL INSURANCE INFOMATION

Primary Dental Insurance

Subscriber's Name_____SS#/ID#_____Date of Birth_____

Subscriber's Employer_____Insurance Plan Name_____Group #_____

Customer Service Telephone_____Patient's relationship to insured_____

Secondary Dental Insurance

Subscriber's Name_____SS#/ID#_____Date of Birth_____

Subscriber's Employer_____Insurance Plan Name_____Group #_____

Customer Service Telephone_____Patient's relationship to insured_____

YOUR HEALTH INSURANCE INFORMATION

Primary Health Insurance

Subscriber's Name_____SS#/ID #_____Date of Birth_____

Subscriber's Employer_____InsurancePlanName_____Group#_____

Patient's relationship to Subscriber _____

CONSENT FOR TREATMENT

1) I hereby authorize the Doctor or designated staff to take x-rays, study models, photograph and any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of _____'s (name of Patient) dental needs.
2) Upon such diagnosis, I authorize Doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
3) I fully agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4) Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in advance of treatment. **Please see attached financial policy for this office.**

_____/_____/_____

Signature **Date**

PHOTO RELEASE

I grant permission to Oelwein Dental Associates to use my intraoral photo and x-rays for educational purposes. Oelwein Dental Associates are able to share "before and after" images to educate and explain procedures and possible results of treatment. **I understand that these photos/x-rays are only of my teeth and that my name or face will not be shown.**

_____/_____/_____

Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

****PLEASE NOTE: A full copy of our Privacy Practices (HIPAA) is available at our reception desk. If you would like to read this document prior to signing below, please let a receptionist know and we will provide you with a copy.**

I_____ have received a copy of the **NOTICE OF PRIVACY PRACTICES (HIPAA)** of this
Your Printed Name
office.

_____/___/___

Print Patient Name **Your Signature** **Date**

_____ _____

Parent/Guardian Printed Name (if patient is under age 18) **Parent/Guardian Signature (if patient is under age 18)**

Oelwein Dental Associates

Patient Name: Birth Date: Date Created:

Dental personnel primarily treat in and around your mouth, your mouth is a part of your entire body.
Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you in good health?	◯ Yes ◯ No	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have there been any changes in your general health within the past year?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Name and Phone Number of your Physician:	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Have you had any joint replacements (knee, hip, shoulder)? If so, what joint and when?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medications containing	◯ Yes ◯ No	If yes
Have you ever been instructed to take an antibiotic prior to dental treatment?	◯ Yes ◯ No	If yes
Do you have any damaged heart valves or artificial heart valves?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant? How Many Months_____ ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine
☐ Acrylic ☐ Metal ☐ Latex
☐ Sulfa Drugs ☐ Local Anesthetics

Other Allergies?

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

AIDS/HIV Positive	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No	Acid Reflux or GI Problems	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Headaches	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Hemophilia	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No	Hearing Impaired	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Artificial Joints (knee, hip)	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No						

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Medications

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Oelwein Dental Associates

Financial Policy

Thank you for choosing Oelwein Dental Associates. Our primary mission is to deliver 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 for our patients as possible by offering several payment options.

☐ **Option A** **PAYMENT IN FULL AT TIME OF SERVICE**

Cash or Check

We offer a 5% courtesy accounting adjustment to patients who pay for their entire treatment with cash or check on the day that dental treatment is performed. (This option is available to those patients without any dental insurance.)

Credit Cards:

We accept Visa, MasterCard, Discover Card or Debit Cards; due to the bank handling charges; we are unable to apply the 5% courtesy adjustment if made by Credit or Debit Cards.

Convenient Monthly Payment Plans[1] from CareCredit

Allow you to pay over time
No annual fees or pre-payment penalties
With this financing, we offer 6 months interest-free financing

☐ **Option B** **PREPAYMENT SAVINGS PLAN**

Pre-pay your account then schedule your appointment. You will receive a 5% courtesy if you pay by check or cash if your planned treatment is paid prior to the appointment.

☐ **Option C** **COVERAGE BY DENTAL INSURANCE**

As a courtesy to our patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment, **we require your co-payment at the time of services**.

Balance in full within one month of receipt of insurance payment. If the insurance company fails to make payment within 90 days, you are responsible for the full amount owed to Oelwein Dental Associates. It is important for you to be informed that our professional services are rendered and charged to **YOU**, not the insurance company. Therefore, you are directly responsible to us for the cost of your treatment.

Dental insurance pays only a portion of your investment. To ensure that you receive maximum benefits, we recommend that you read your insurance booklet and become familiar with your specific plan requirements.

Please note:
If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

In the case of a divorce situation, please be aware that the parent bringing the child into this office for dental care is legally responsible for payment of all fees.

Oelwein Dental Associates charges $25 for returned checks.

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

A monthly finance charge of 1.5% is imposed on all accounts over 90 days (18% annually) If 90 days has passed since your last payment, your account may be considered for small claims court.

I have read the above financial policy and indicated which payment option that I have chosen by placing an "X" in the box preceding that option.

_____ _____

Signature Date

This Financial Policy is effective 10/01/2012

[1]Subject to credit approval