NIELSEN
DENTAL STUDIO

Welcome to Our Practice!

We are committed to providing exceptional dental care to our patients in a compassionate, professional environment. The following information is provided to introduce you to our practice philosophy and policies.

Appointments

Appointments are scheduled so we can provide the most efficient care in a relaxed setting. We make every effort to honor time commitments and we appreciate patients extending us the same courtesy. Patients are reminded of their appointments 2-3 days in advance by email, text, or phone. Patients are kindly asked to confirm their appointment at least 48 hours prior to their appointment through the reminder method employed.

Urgent Care After Hours

We accommodate patients of record who experience dental emergencies after hours. A patient of record is one who has been seen and treated in the office during the past 18 months. If you are a patient of record and have a dental emergency, you can call the office for information on how to contact us. ***An after hours fee may be charged.***

Children and Adolescents

We are happy to start seeing children at the age of three. Parents are welcome to accompany their children in the operatories. We require that parents remain in the office with children under the age of 18 for the entire appointment. Failure to comply may result in the appointment being rescheduled.

Payments and Insurance

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. As a result, we offer several payment options, including cash, check, credit card, and third party financing. For patients with dental insurance, we will file the appropriate claim forms.

Cancellations and Missed Appointments

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee of $25. **I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.**

Patient Signature:_____Date:_____

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Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: _____ /_____ /_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Brochure/Flyer	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_____	

Whom may we thank for referring you to our practice?_____

Insurance Information (Primary)/ Responsible Party

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: _____ /_____ /_____ Employer: _____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address: _____

Group #: _____ ID #: _____

Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: _____ /_____ /_____ Employer: _____

Insurance Plan Name: _____ Insurance Co Phone #:_____

Claims Address: _____

Group #: _____ ID #: _____

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Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____

2. Have you ever had any excessive bleeding requiring special treatment? Yes No

3. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

4. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

5. Please list other medications you are taking:

_____

6. Date of last dental exam: _____ Date of last dental x-rays: _____

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Pacemaker	Yes No
Eating Disorder	Yes No	Arthritis	Yes No	Heart Surgery	Yes No
Epilepsy/Seizures	Yes No	Liver Disease	Yes No	Persistent Cough	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A/B	Yes No	Hay Fever	Yes No
Psychiatric TX	Yes No	Hepatitis C/D	Yes No	Tobacco Products	Yes No
Jaundice	Yes No	Artificial Joints	Yes No	Night Sweats	Yes No
Kidney Trouble	Yes No	Thyroid Disease	Yes No	Stroke	Yes No
Diabetes	Yes No	Anemia	Yes No	Drug Addiction	Yes No
Cancer	Yes No	MVP	Yes No	Sinus Trouble	Yes No

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date:_____

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Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. Therefore, we are pleased to offer several payment options. Please read the following carefully. Our financial coordinator will answer any questions you may have, and assist you in selecting the appropriate financial plan for your needs.

For your convenience, we offer the following financial options:

1. In addition to personal checks and cash, we also accept payment through MasterCard/Visa, American Express, and Discover.
2. We offer extended payment plans for amounts up to $25,000 upon approved credit. This plan has the following features:

- No down payment
- Extended terms with low monthly payments.
- No prepayment penalty.
- No interest up to 12 months.

3. Dental Insurance

- Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage, and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.
- Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.
- Our participation in a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits within the PPO.

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy. **I have read the Financial Policy. I understand and agree to this Policy.**

Signature: _____ Date_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____

Signature Date

----------FOR OFFICE USE ONLY----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)