Genuine Dentistry

FAMILY, COSMETIC, IMPLANTS

Dental Patient Screening Form

Patient Name: (First) _____ (Last) _____ **Birthdate:** _____

	Pre-Appointment Self-Assessment Date:	**OFFICE USE ONLY** Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? **Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.**	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

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FINANCIAL POLICIES

Your Genuine Dentistry practice is committed to providing exceptional service and treatment that addresses both your short- and long-term needs. With our Peace of Mind Promise, we make it easier for you to get the care you need at affordable prices–no hidden fees, no surprises.

1. A Clear, Written Estimate on your Cost of Treatment

Your dentist will provide you with a comprehensive treatment plan based on your overall health. You'll also receive a clear, detailed estimate of the cost of your plan, including your estimated insurance benefits. If you have questions regarding your insurance coverage, please contact your insurance company.

2. Payment Policy

Full payment of what you owe (called the Patient Financial Responsibility amount, as noted in your Treatment Acceptance and Payment Arrangement Form), is due when services are rendered. We accept cash, personal checks, Visa®, Master Card®, American Express®, Discover® and assigned insurance benefits.

3. Refund Policy

If you are reconsidering treatment you have not yet received but have already paid for, you may cancel treatment and request a refund at any time for the amount you paid. Note: Crown and bridge patients are responsible for the full cost of their treatment plan once preparation of your teeth has begun. Invisalign patients are responsible for the full cost of all laboratory costs and scan fees once fabrication of your aligns has begun.

Your refund request will be handled as follows:

• Original Form of Payment: Refunds will be applied to the original form of payment, with the exception of cash payments, which will be refunded by check.

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Notice of Privacy Policies

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect.

Uses and Disclosures of Health Information as follows:

[Treatment]
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

[Payment]
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

[Health Care Operations]
We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

[Your Authorization]
In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

[Required by Law]
We may use or disclose your health information when we are required to do so by law.

[Appointment Reminders]
We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

[Sign-In Sheet and Announcement]
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

I have had full oppotunity to read and consider the contents of the Notice of Privacy Practices.

Patient Name: Account #: Patient Code: Date:

Patient, Pharmacy and Insurance Information

Patient Information

Prefix: _____ First Name: _____ Middle Name: _____ Last Name: _____

Suffix: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Preferred Phone #: _____ Is this a mobile number? Yes ☐ No ☐

Email Address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unspecified

Emergency Contact: _____ Emergency Phone #: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Date of Birth: _____ Sex: ☐ Female ☐ Male ☐ Unspecified

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Street: _____ Zip: _____ City: _____ State: _____

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: Date of Birth:

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Secondary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Patient Name: Account #: Patient Code: Date:

Health History

Reason for Visit: ☐ Broken Tooth ☐ Check-up ☐ Cosmetic ☐ Dentures ☐ Tooth Pain ☐ Other: _____

Height: _____ ft _____ in Weight: _____ Patient Date of Birth: _____

Are you under the care of a primary physician? ☐ Yes ☐ No

Primary Physician's Name: _____ Physician's Phone Number: _____

Date of Last Physical:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?

☐ No ☐ Yes How Long? _____

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Are you allergic or have you had an adverse reaction to any of the following?

☐ **None** ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex ☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline

☐ Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

☐ **None**

Check any conditions that apply to you:

☐ **None**

☐ Alcoholism

☐ Allergies or Hives

☐ Anemia

☐ Arthritis

☐ Artificial Joint/Pins

Type: _____

Age: _____

☐ Aspirin Therapy

☐ Asthma

☐ Blood Thinners

☐ Blood Transfusion

☐ Breathing Problems

☐ Cancer

Type: _____

☐ Chemotherapy

☐ Coumadin Therapy

☐ Dementia

☐ Diabetes

Type: _____

☐ Dialysis

☐ Drug Addiction

☐ Epilepsy

☐ Excessive Bleeding

☐ Fainting/Dizziness

☐ Hearing Impairment

☐ Heart Murmur

☐ Heart Surgery

Date: _____

☐ Heart Trouble

Type: _____

☐ Hepatitis

Type: _____

☐ High Blood Pressure

☐ HIV

☐ Kidney Disease

☐ Liver Disease

☐ Low Blood Pressure

☐ Lung Disease/COPD

☐ Lupus

☐ Mitral Valve Prolapse

☐ Mobility Impairment

☐ NON-DENTAL Implants

Type: _____

☐ Organ Transplants

Type: _____

☐ Pace Maker

☐ Psychiatric Care

☐ Radiation Therapy

☐ Radiosurgery

☐ Rheumatic Fever

☐ Seizures

☐ Sexually Transmitted Disease

☐ Sinus Problems

☐ Stomach Problems

☐ Stroke

☐ Thyroid Disease

☐ Tuberculosis(TB)

☐ Ulcers

☐ Visual Impairment

☐ Other Disease/Illness

Type: _____

Patient Name: Account #: Patient Code: Date:

Dental History

Date of Last Dental Visit:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Date of Last Dental X-ray:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? ☐ Yes ☐ No

Age of dentures: ☐ Less Than 6 Months ☐ 6 months-3 years ☐ Greater than 4 years

Please check any conditions that apply to you below:

☐ Pain In Jaw(TMJ) ☐ Teeth Grinding/Clenching ☐ Use Tobacco Products ☐ Mouth Sores

☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date: _____

Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____

6 MONTH UPDATE

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____

Patient Signatures

Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

☐ all treatment information

☐ information specifically related to these treatment dates

Starting Date: _____ End Date: _____

Consent to obtain patient medication history (Optional)

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature: _____ Date: _____

Payment, Insurance and Financial Arrangement Policies (signed by ALL new patients)

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Notice of Privacy Practices (must be signed by ALL new patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)