HAWORTH
—DENTAL—

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(201)384-1717

Welcome!

Thank you for your visit today! We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask – we will be glad to help. We look forward to working with you!

Patient Information

Name_____ Home Phone _____

Social Security #_____ Drivers Lic # _____

Address _____Cell Phone_____

City _____ State _____Zip Code _____ E-Mail_____

Gender □ Male □ Female Age _____ Birthdate _____□ Single □ Married □ Widowed □ Other

Occupation _____ Employed by _____

Business Address _____ Work Phone _____

Whom may we notify in case of an emergency? _____ Phone _____

Whom may we thank for referring you to our practice? ___Friend ___Relative ___Dental Office ___Web Site ___Insurance

___News Paper/Magazine ___Work ___Yellow Pages ___Other

Name of referral?_____

Are you a FT Student? _____Yes ____No Name of School/ University?_____

Primary Insurance

Who is responsible for this account?

Name _____ Phone Number_____

Relation to patient _____ Birthdate _____ Social Security # _____

Address (if different from patient's) _____ E-Mail_____

City _____ State _____ Zip Code _____

Employed by _____ Occupation _____

Business Address _____ Work Phone _____

Insurance Company _____

Contract or Group # _____ Subscriber # _____

Secondary Insurance

Is patient covered by additional insurance? □ Yes □ No

Subscriber name _____ Relation to patient _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip Code _____

Subscriber employed by _____ Work Phone _____

Insurance Company _____ Social Security # _____

Contract or Group # _____ Subscriber # _____

Reason for today's visit _____ Are you in discomfort?_____
Previous Dentist _____ Address _____
Date of Last Dental Care _____ Do you take antibiotics before dental appointments?_____

Please check (✔) if you have had trouble with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Grinding Teeth
- ☐ Loose Teeth/ Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity when biting
- ☐ Sores or Growths in Mouth
- ☐ Frequent cold sores
- ☐ Food Caught between Teeth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date) _____

_____

Have you ever had a blood transfusion: ☐ yes ☐ no If yes, please give approximate date _____

Women: Are you pregnant or trying to become pregnant? ☐ yes ☐ no Nursing? ☐ yes ☐ no Taking birth control? ☐ yes ☐ no

Please check (✔) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems

  Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Please list any medications you are currently taking _____

Please list any allergies,or allergic reactions to medications you have taken:_____

Do you have any other health conditions that need further clarification?_____ Do you take blood thinners?_____

CONSENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. The undersigned hereby authorizes Dr. Harris to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Harris to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Harris to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain amount of risk. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Dr. Harris and that **I am still fully responsible for all dental fees**. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to Dr. Harris. Any payments received by Dr. Harris from my insurance carrier will be credited to my account, or refunded to me if I have paid the dental fees incurred at the time of service. I further understand that a late charge will be added to any overdue balance (1.5% per month or 18% annually). In the event my account is referred to a collection agency or attorney, I will be responsible for all collection fees and/or legal fees due to the delinquency of my account.

Patient Name:_____ Patient Signature: _____
(or parent/guardian)

Date: _____Dentist Signature: _____Comments_____

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OFFICE POLICY

In order to accommodate the needs and request of our patients, we have enrolled in numerous insurance programs. Even if we are NOT a contracted provider, (as a courtesy) we submit claims, and wait for the established percentage of the dental fee.

While we are pleased to be able to provide this service for you, it is extremely difficult for us to keep up to date with all the specific, and or various requirements of each and every plan, WITHOUT YOUR FULL COOPERATION. Please understand that each plan has different stipulations. **IT IS VERY IMPORTANT THAT YOU, THE PATIENT, BE FULLY AWARE OF HOW YOUR PLAN WORKS PRIOR TO THE TIME OF YOUR SCHEDULED APPOINTMENT.**

If you have questions regarding your dental plan, or a problem with your reimbursement level, PLEASE contact your insurance carrier, or your employer. Each contact varies and it is difficult for us to predict what your level of coverage will be. Many companies revise their dental contracts on a yearly basis. It is impossible for us to know what has changed with your dental plan year to year. We fully expect you, the patient, to be cognizant of any and all changes that have been made. The dental benefit contract is between you, your employer and your chosen insurance company. Dr. Harris and Harris Dental Care are NOT RESPONSIBLE for knowing your insurance benefits, changes that may have been made to your contract, financial allowances that have been used and precise reimbursement levels for treatment to be rendered.

With your full understanding and cooperation, we, your health care provider, can provide you with the dental benefits which you are entitled.

*****I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FULL RESPONSIBILITY AS DESCRIBED ABOVE.**

_____	_____	_____
(Print Name)	(Signature)	(Date)

Appendix 2.22.3
Agreement to Receive Electronic Communication

This form illustrates how HaworthDental obtains a patient agreement to receive communications via email.

Patient Name: _____ Date of Birth:_____

I agree that Harris Dental Care may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

_____**[201-384-1717].**

Email Address (PLEASE PRINT CLEARLY):
_____@_____

Patient Signature:_____

Date:_____