PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ (If minor, parents names _____)

Birth date_____ Social Security number _____

Home phone _____ Cell phone _____ Work number_____

Mailing address _____ City _____State _____ Zip _____

Email Address _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Emergency Contact Name_____ Phone Number_____ Relationship_____

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

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Dental Insurance Co._____ Group number_____ Subscriber/Member ID _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's birthday _____ Spouse's Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

Signature of patient (or parent) _____ Date _____

Office Policies

Welcome to the dental office of Dr. R. Corey Snow, DMD, P.A. Our goal is to provide you with the best dental care possible. Please carefully review our office policies:

Dental Insurance Claims and Payments. It is our policy to request estimated co-payments for services at the time they are rendered. Our office will file your insurance claims and pre-determinations as a courtesy to you, however, payment for deductibles and estimated co-payments is expected as treatment is rendered. We accept cash, check, Visa, MasterCard, Discover, CareCredit, Lending Club and GreenSky. Please keep in mind that you are ultimately responsible for all charges. Please review your insurance benefits material to determine if a predetermination of benefits is necessary to receive payment for treatment. Remember you are personally responsible for the total charge of any treatment which is not covered by your insurance plan.

Broken Appointments. If you cannot keep your scheduled appointment, please contact our office at least 48 hours prior to that appointment. If you schedule an appointment with our office and fail to show up, a broken appointment fee of $40 will be assessed per hour reserved, unless you have provided us with advanced notice.

Minors. If a patient is a minor, a parent or guardian must be present at the first visit and any subsequent visit.

Additional Charges. Please note that insurance companies will typically only pay for what they consider basic or minimally acceptable treatment. This generally does not include Nitrous Oxide/ Laughing Gas, adult fluoride treatments, Soft/Hard Tissue Laser treatments, and cosmetic procedures.

Dental Insurance Benefits. Each insurance plan has its own policies and are subject to change. Therefore, we cannot be responsible for guaranteeing that you will receive coverage for the dental procedures which you request. If your insurance does not cover your treatment, you will be responsible for those fees at the time of service. We will be happy to discuss our office fees with you at any time.

Emergency Appointments. If you schedule an emergency appointment, we must focus on the primary problem, postponing any additional treatment for a future appointment. This ensures that we are best prepared to accommodate your needs and protect your health. An initial emergency appointment is generally for an evaluation only, and we cannot guarantee that there will be time to perform definitive treatment
I have read the above and agree to abide by these office policies.

_____ (Patient/Guardian) _____ (Date)

INFORMED CONSENT

I hereby authorize Dr. Snow and his assistants, and/or hygienists, to perform upon me the dental procedures that we discuss. If any unforeseen condition arises in the course of designated procedures calling, in his judgment, for procedures in addition to or different from those now contemplated, I further request and authorize whatever he deems advisable.

I understand that there are certain risks in any dental treatment. These risks include, but are not limited to, post treatment pressure and temperature sensitivity, pain, nerve inflammation, and sensitivity of teeth and gums during and following dental treatment. Other less common risk include but are not limited to, infection, injury to adjacent teeth and gums, swallowing or aspiration of a part of a tooth or filling and nerve disturbance (e.g. numbness in mouth and lip tissues). These complications that result from these risks may be temporary or permanent.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drugs or anesthesia. This risk includes, but is not limited to, following complications; adverse drug response (e.g. allergic reactions), irritation and swelling of a vein, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

A more complete explanation of all risk and complications is available to me upon my request from the doctor. In spite of the possible complications and risks my treatment is necessary and desired by me.

DATE PATIENT/PARENT/GUARDIAN SIGNATURE DOCTOR/STAFF

__/__/__ _____ _____

PLEASE PRINT:_____

Snow Dentistry

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____