Date

Patient
Street Address
City, State Zip Code

Dear Patient,

Copper Bend Family Dental would like to welcome you to our practice. It is where we get to the root of the problem. We are pleased that you have chosen us to care for your dental needs. We pride ourselves on making dentistry a pleasant experience. Our commitment is to provide you with the best dental care possible. We want to make you proud to smile.

One of our goals is to help you keep your teeth for a lifetime. We can reach this goal only by keeping you well informed at all times. This letter is to let you know what to expect during your first visit.

During your first visit, I will conduct a thorough examination of your mouth, teeth, gums and soft tissue and complete a cleaning. The exam may include necessary x-rays to accurately determine the condition of your oral health. Following a careful diagnosis, we will discuss a treatment plan suitable to your needs. When treatment is indicated, we will try to restore optimum dental health in a few well-planned visits.

Enclosed you will find a health questionnaire and consent forms. Please complete the questionnaire and bring the forms with you to your first visit. If you have dental insurance, please make sure to bring your card and a photo ID with you.

If you have any questions, please do not hesitate to give us a call. We look forward to seeing you on _____.

Yours in dental health,

Dr. Jessica Lavalle, D.M.D

PATIENT REGISTRATION

Today's Date _____

Patient Number ABC

Patient's Name _____ Sex: M F Birthdate _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Please Circle One: Single Married Separated Widow Your Soc. Sec. # _____

Home Ph.# _____ Cell Ph. # _____ E-mail Address _____

Your Employer _____ Work Ph. # _____ How Long Employed _____

Are you a full time student? ☐ Yes ☐ No *If patient is minor we need:* *Mother's DOB* _____ *Father's DOB* _____

Person responsible for account _____ Driver's License # _____ Relationship _____

Name of spouse (parent if minor) _____ Spouse's (parent's) Soc. Sec. # _____

Spouse's (parent's) Employer _____ Work Ph. # _____ Cell Ph. # _____

EMERGENCY INFORMATION
Name, address, & telephone of a relative not living with you _____

Reason for this visit _____

How did you hear about our office? _____

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have double digit insurance coverage, complete this for the 2nd coverage**
Insured's name	Insured's name
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone # DOB	Phone # DOB
SS#	SS#
Group # Local #	Group # Local #

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard Visa and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ☐

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payme regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance compa to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, (Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter int dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BEN FITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is m due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agre any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent if child) **Date**

Copper Bend Family Dental

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area 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. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	_____
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

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 _____ DATE _____

Copper Bend Family Dental

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Cummins Family Dental. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

In addition I give my permission to send PHI via e-mail in an unencrypted format to any referring doctors.

_____

* * *

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) _____

Staff Person Initials _____

Copper Bend Family Dental
Dr. Jessica J. Lavalle, D.M.D
Creating Happy, Healthly Smiles!

Dental History

What is the most important thing to you about your visit today? _____

How did you hear about Copper Bend Family Dental? _____

Date of your last dental exam? _____

Date of your last cleaning? _____

Please Circle Yes or No to the Following

Do you have any sensitivity/pain in your mouth?	Yes	No
Do you have broken/chipped teeth you want repaired?	Yes	No
Do you have amalgam/old fillings you want replaced?	Yes	No
Do you want your teeth professionally whitened?	Yes	No
Do you have missing teeth you want replaced?	Yes	No
Do you want your teeth straightened?	Yes	No
Do you want any old crowns replaced for any reason?	Yes	No

Do you grind/clench?
Yes No

Do you experience bad breath?	Yes	No
Do you have loose or shifting teeth?	Yes	No
Do you have swollen, painful, or bleeding gums?	Yes	No
Do you have TMJ or jaw joint pain?	Yes	No
Do you have swelling or pain from a possible tooth infection?	Yes	No