PAR Dental

32 S Richards Run • Springboro, OH • 45066
937-748-4700 • pardental.com • info@pardental.com

About You

Patient Name _____

SSN # _____

Address _____

City _____ ST ____ Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Birth date _____ ☐Male ☐Female

☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

If Student, Name of School _____

Please check all the ways you heard about our office

☐ Friend/Family ☐ Internet ☐ Face book
☐ Insurance ☐ Print Ad Other_____

If a friend or family member referred you, we would like to thank them. To whom may we send our thanks?

_____

Employer _____

Occupation _____

Spouse/Partner Name _____

Spouse/Partner Employer _____

Spouse/Partner Phone _____

Spouse/Partner Birth date _____

Responsible Party

Person Responsible for this Account _____

Address _____

City _____ ST ____ Zip _____

Relationship to Patient _____

Employer _____

Payment in full is required at each appointment. For your convenience we offer the following methods of payment. I prefer to pay via:

☐ Cash ☐Check ☐Visa ☐MC ☐Disc ☐Amex

I hereby authorize assignment of my insurance benefits directly to the provider for services rendered. I fully understand that I am responsible for all charges to my account regardless of the decision of my insurance company to pay or deny benefits for any reason. I also understand that a fee for missed appointments with less than 2 business day's notice will be assessed to my account. No appointments will be made until this fee is paid.

_____ Date_____

Signature of Patient/Parent if under 18/Guardian

Dental Insurance Info

Primary Insurance:

Insured's Name _____

Relationship to Patient _____

Birth date _____ ☐ Male ☐Female

Employer _____

Work Phone _____

Insurance Carrier _____

Ins. Co. Address _____

City _____ ST____ Zip_____

Policy/ID # _____

SSN # (if no policy #) _____

Group # _____

Deductible $ _____ Annual Maximum $ _____

Secondary Insurance:

Insured's Name _____

Relationship to Patient _____

Birth date _____ ☐Male ☐ Female

Employer _____

Work Phone _____

Insurance Carrier _____

Ins. Co. Address _____

City _____ ST____ Zip_____

Policy/ID # _____

SSN # (if no policy #) _____

Group # _____

Deductible $ _____ Annual Maximum $ _____

In Case of Emergency

Whom should we contact? _____

Relation _____

Home Phone _____

Cell Phone _____

Work Phone _____

Patient Name _____

Medications

During the past year have you taken any of the following?

- ☐ Antibiotics
- ☐ Anticoagulants(e.g.Coumadin)
- ☐ Tranquilizers
- ☐ Drugs for heart problems
- ☐ Cortisone
- ☐ Vitamins
- ☐ Other (List)
- ☐ Sulfa drugs
- ☐ High blood pressure meds
- ☐ Insulin
- ☐ Nitroglycerin
- ☐ Birth Control Pills
- ☐ Herbal Supplements
- ☐ Diet Pills

☐ Have you ever taken any **bisphosphonates** oral or iv such as **Boniva**, **Fosamax, Actonel, Zometa, Aclasta?** If so please list:

_____

_____

_____

Allergies

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

- ☐ Latex
- ☐ Penicillin
- ☐ Barbiturates, sedatives, sleeping pills
- ☐ Other Narcotics
- ☐ Local Anesthesia
- ☐ Codeine
- ☐ Aspirin
- ☐ Other Medicine

Medical History

Please check if you have, or have had any of the following medical conditions:

- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Low Blood Pressure
- ☐ Stents
- ☐ Heart Transplant
- ☐ Irregular Heart Beat
- ☐ Pacemaker
- ☐ Cancer of any Kind
- ☐ Radiation Treatment
- ☐ Diabetes
- ☐ Asthma
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Frequent Diarrhea
- ☐ Hemophilia
- ☐ Hepatitis A, B or C
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Multiple Sclerosis
- ☐ Stomach/Intestinal
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Glaucoma
- ☐ Congenital Heart Disease
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Stroke
- ☐ Chest Pain
- ☐ Angina
- ☐ Chemotherapy
- ☐ Artificial Joints
- ☐ Shortness of Breath
- ☐ Blood Disease
- ☐ Epilepsy or Seizures
- ☐ Excessive Thirst
- ☐ Frequent Cough
- ☐ Herpes
- ☐ HIV/Aids
- ☐ Hypoglycemia
- ☐ Leukemia
- ☐ Renal Dialysis
- ☐ Rheumatism
- ☐ Shingles
- ☐ Multiple Dystrophy
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Hay Fever

Are you under a physician care now? ☐ Yes ☐ No

If yes explain _____

Have you ever been hospitalized or had a major surgery? ☐ Yes ☐ No

If yes explain _____

Do you know of any reason to take a pre-medication prior to medical or dental care? ☐ Yes ☐ No

Do you use controlled substances ☐ Yes ☐ No

Are you experiencing dental pain now? ☐ Yes ☐ No

If so, where? ☐ Upper Left ☐ Upper Front ☐ Upper Right ☐ Lower Left ☐ Lower Front ☐ Lower Right

Is the pain associated with?

☐ Biting ☐ Sweets ☐ Cold ☐ Heat ☐ Air

Are you taking any medications for this pain? ☐ Yes ☐ No

Does food become lodged between teeth? ☐ Yes ☐ No

Does your breath concern you? ☐ Yes ☐ No

Are you apprehensive about dental treatment? ☐ Yes ☐ No

Do you have difficulty chewing your food? ☐ Yes ☐ No

Do you avoid chewing in part of your mouth due to pain? ☐ Yes ☐ No

Do you avoid brushing or flossing part of your mouth due to pain? ☐ Yes ☐ No

Have you ever been diagnosed with periodontitis or periodontal disease? ☐ Yes ☐ No

Have you ever noticed slow healing sores in your mouth? ☐ Yes ☐ No

Do you smoke or chew tobacco? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you have any other medical conditions? ☐ Yes ☐ No

Please list:

_____

_____

Women:

Are you Pregnant/Trying to get pregnant? ☐ Yes ☐ No

Taking Oral Contraceptives or hormones? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

I understand that the information I have provided on these forms is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be necessary, you have my permission to request that information from the respective health care provider and for them to release to you. I will notify the doctor of any change in my health or medication.

_____ Date_____

Signature of Patient/Parent if under 18/Guardian

_____

Printed Name

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We believe that all patients deserve to know, up front, our financial policies. Below are our policies relating to your dental care.

Payments at time of service:

At the time of service, your estimated co-payment is due. For procedures with multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $500 or more, a 10% deposit is required to secure your initial treatment appointment.

Dental Insurance:

As a courtesy we will file your insurance claim for you. We offer this service to you as a courtesy only and it is not meant to be a Substitute for payment. We will attempt to collect from your insurance carrier their portion of the charges for your visit. We cannot guarantee that they will pay any amount for your treatment. Each plan has different exclusions and limitations and those exclusions and limitations change over time. Our office recommends dental treatment based on medical necessity and not on whether your insurance company will cover a procedure. It is your responsibility to pay any amount not covered by your insurance company regardless of the reason. We will instruct your insurance carrier to send all payments directly to our office for reimbursement.

Pre-Determination of Insurance Benefits:

We will file, upon your request, a request for pre-determination of dental benefits from your insurance carrier.

A pre-determination is a process whereby your insurance company tells you in advance of treatment what procedures may be covered and the amount of benefits your plan may pay towards those procedures and the amount you may be required to pay. A Pre-determination of benefits reduces, but does not eliminate the risk of error in estimating your co-payment. A pre-determination is not a guarantee of coverage. Pre-determination sets forth your expected benefits based on the information provided to the carrier at the time of processing. If your plan changes, additional claims are received after the pre-determination is processed or your oral condition changes then the pre-determination is not valid and may need to be resubmitted. Depending on your insurance carrier, a pre-determination may take up to three weeks to process.

Third-Party Financing:

PAR Dental offers financing options through various third-party lenders. Arrangements for these options must be made in advance of your appointment.

Returned Checks:

Any check returned for any reason by your bank will be assessed a $35 fee.

I have read, understood and agreed to all of the above Financial Policies of PAR Dental and PAR Family Dental LLC., I understand that treatment cannot begin until this form is signed and agreed to.

Date _____

_____

Signature of Patient/Parent if under 18/Guardian

_____

Printed Name