

### Thank you for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely.  
 If you have any questions or need assistance, please ask us and we will be happy to help.

#### Patient Information

			Today's Date	
Name		Birthday		Social Security Number
Address		City		State
				Zip Code
Home Phone		Business Phone		Cell Phone
Email Address - Would you like to receive appointment reminders by email?			Drivers License Number	
Marital Status		Patient Employer		Occupation
Single Married Divorced Widowed Other				
Employer Address		City		State
				Zip Code
Spouse / Partner Name		Spouse / Partner Phone		Relationship to Patient
Whom / what may we thank for referring you?				
Emergency Contact (Someone who does not live with you)		Emergency Contact Phone Number		Relationship to Patient

#### Responsible Party

Name of Person Financially Responsible for this Account				
Relationship to Patient			Is this Person a Patient in Our Office?	
Address (if different from above)		City		State
				Zip Code
Social Security Number		Birthday		Drivers License Number
Home Phone		Business Phone		Cell Phone

#### Primary Dental Insurance Information

Name of Insured			Relationship to Patient	
Social Security Number		Birthday		Drivers License Number
Name of Employer			Date Employed	
Employer Address		City		State
				Zip Code
Insurance Company		Group Number		Employer Number
Insurance Company Address		City		State
				Zip Code

#### Additional Dental Insurance Information

Name of Insured			Relationship to Patient	
Social Security Number		Birthday		Drivers License Number
Name of Employer			Date Employed	
Employer Address		City		State
				Zip Code
Insurance Company		Group Number		Employer Number
Insurance Company Address		City		State
				Zip Code

## Medical History

Patient Name	Birthday
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Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 ever taken, Phen-Fen or Redux?  Yes  No  
If yes, please explain? \_\_\_\_\_
  - Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No  
If yes, please explain? \_\_\_\_\_
  - Are you on a special diet?  Yes  No
  - Do you use tobacco?  Yes  No
  - Do you use controlled substances?  Yes  No
- 
- 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?
- |   |  |   |   |
|---|--|---|---|
| <ul style="list-style-type: none"> <li>AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Anephiaxis <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> | <ul style="list-style-type: none"> <li>Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> | <ul style="list-style-type: none"> <li>Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> | <ul style="list-style-type: none"> <li>Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> |
|---|--|---|---|

• Have you ever had any serious illness not listed above?  Yes  No If yes, please explain? \_\_\_\_\_

## Patient Dental History

Name of Previous Dentist	Last Exam Date
--------------------------	----------------

- |  |   |   |
|--|---|---|
| Do your gums bleed? <input type="checkbox"/> Yes <input type="checkbox"/> No             | Do you like your smile/color of teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have sores/lumps in mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Do you clench/grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No    | Do you wear dentures/partials? <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Do you bite your lips/cheeks? <input type="checkbox"/> Yes <input type="checkbox"/> No   | Do you have pain or sensitive teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No   | Have you had head/neck/jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No |

## Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or health care practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Health Insurance Portability and Accountability Act

Please answer all the questions may marking the appropriate box/filling in blanks. Thank you.

Patient Name

- May we audibly say your name in our patient lobby, in order to identify you?  Yes  No
- May we use all of your contact numbers and addresses to stay in touch with you?  Yes  No
- May we leave messages in your absence?  Yes  No
- With whom may we discuss your dental care?

Name

Relationship to Patient

- Who can pick up your written prescriptions?

Name

Relationship to Patient

- We routinely give reminder calls prior to appointments. Where can we reach you?

Home Phone

Business Phone

Cell Phone

- May we call you at work?  Yes  No

### Consent Related to the Privacy Notice:

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the privacy notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but the practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Signature of Patient/guardian \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date \_\_\_\_\_

Patient Unable To Sign Due To: \_\_\_\_\_

Patient Refused To Sign

Witness \_\_\_\_\_

Date \_\_\_\_\_

## Appointment Guidelines & Agreement

Since providing quality treatment for all of our patients in a timely manner is a major focus on our practice philosophy, we would like to clarify our appointment guidelines with you and ask that you assist us in this endeavor.

There will be absolutely no charge for your need to reschedule an appointment provided you give us 48 hours notice and that you contact us during business hours, this would allow us the opportunity to give this time to another patient who is in need and waiting.

Last minute cancellations can cause hardships for many individuals. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice.

Thank you.

\_\_\_\_\_  
Signature of Patient/guardian

\_\_\_\_\_  
Date

Maria Van Huffel, D.D.S. \_\_\_\_\_ (Initial)

Thank you for choosing our office for your dental needs. We do our absolute best to help you estimate your insurance benefits. As a courtesy, our office will verify your insurance with your insurance carrier as long as you provide us with your correct insurance information no less than 2 business days before your appointment. We will file your dental claim with your insurance carrier. Keep in mind all insurance companies include a disclaimer stating verification does not guarantee payment.

Due to the thousands of insurance plans, it would be impossible for us to know all benefits, allowances and limitations on all plans. You must be familiar with your own benefits. Your dental insurance plan is a contract between you, your employer, and the insurance company. It is your responsibility to know the benefits, limitations and exclusions of your dental plan. If you are unhappy with your coverage, please contact your Human Resources Department. Only your employer can change the policy. We are not responsible, nor can we guarantee, how your insurance carrier will pay on a claim.

When Dr Van Huffel recommends treatment, you will always be presented with a treatment plan for the services. Treatment plans sometimes change during the course of treatment because conditions worsen and therefore your financial responsibility would also change. This would always be discussed with you before service is rendered. The entire fee for services is your responsibility regardless of insurance involvement. Because your insurance company makes no guarantee of payment, we cannot guarantee your exact insurance coverage. Your deductible and estimated portion are due at the time services are rendered; this includes any children coming to appointments without parents. You may receive a statement with an additional balance after your insurance has paid the portion they decide to pay. Once the insurance carrier has paid, the remaining balance is still your responsibility.

We are always available to answer your questions and assist you in any way we can.

Thank you,

Dr. Van Huffel

I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for treatment performed on me and my dependents. It is my responsibility to notify the office of any changes in my insurance. I understand that payment will be due on the day service is rendered, even if my child comes to the office without a parent.

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Sign Name

Print Name

Date