ICON DENTAL
CENTER

PATIENT INFORMATION – *please print*

Legal Name (first &last) _____ Preferred Name _____

Date of Birth _____/_____/_____ Age: _____ Sex: M/F Social security number (*required*) _____ - _____ - _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home phone (_____) _____ - _____ Mobile phone (_____) _____ - _____ Other (_____) _____ - _____

Email Address _____@_____ .com

Our office uses an electronic reminder system. How would you like to receive your reminder? (Circle any that apply)

Text Message | Email | Phone call

How did you hear about our office? _____

EMERGENCY CONTACT

Name (first & last) _____

Phone Number (_____) _____ - _____ Relationship to patient _____

DENTAL INSURANCE

Policy holder Name _____ Date of Birth _____/_____/_____

Social security number (required) _____ - _____ - _____ Identification Number _____

Group Number _____ Employer _____

SECONDARY INSURANCE (if applicable)

Policy holder Name _____ Date of Birth _____/_____/_____

Social security number (required) _____ - _____ - _____ Identification Number _____

Group Number _____ Employer _____

DENTAL HISTORY

What is the reason for your visit today? _____

Are you apprehensive about dental treatment? _____ Have you had problems with previous dental treatment _____

If yes please describe_____

Are you interested in: Whitening your teeth___ Braces/Invisalign___ Cosmetic treatment___

DENTAL HISTORY

Previous Dentist _____ Phone number _____

When was your dental exam/cleaning? _____

Do you have any immediate concerns/pain? _____

Please circle YES or NO if you have, or ever had the following:

Unhappy with appearance of your teeth	**YES | NO**	Burning sensation in the mouth	**YES | NO**
Unfavorable dental experience/fear	**YES | NO**	Difficulty swallowing	**YES | NO**
Preference for no dental anesthetic	**YES | NO**	Unpleasant taste or odor in your mouth	**YES | NO**
Difficulty/Reactions to dental anesthetic	**YES | NO**	Jaw problems/pain/clicking/locking	**YES | NO**
Orthodontic treatment/Braces	**YES | NO**	Difficulty opening wide	**YES | NO**
Periodontal (Gum) treatment	**YES | NO**	Stiff neck muscles	**YES | NO**
Bleeding Gums	**YES | NO**	Tension headaches	**YES | NO**
Avoid brushing any parts of your mouth	**YES | NO**	Clench or grind your teeth	**YES | NO**
Sensitivity to temperature in the mouth	**YES | NO**	Sore teeth	**YES | NO**

ALLERGIES *mark all that may apply*

ASPIRIN, ACETAMINOPHEN, or IBUPROFEN___ PENICILLIN___ OTHER ANTIBIOTICS___ CODEINE/NARCOTICS___

LATEX___ FLUORIDE___ LOCAL ANESTHESIA___ METALS___ SULFA___ OTHER

MEDICAL INFORMATION

Physician or Clinic name _____ Phone (_____) _____ - _____

Please circle YES or NO if you have, or ever had the following;

Anemia	**YES | NO**	Cough up blood	**YES | NO**	Narcolepsy	**YES | NO**
Angina	**YES | NO**	Diabetes	**YES | NO**	Kidney Disease	**YES | NO**
Anxiety	**YES | NO**	Epilepsy	**YES | NO**	Liver Disease	**YES | NO**
Arthritis	**YES | NO**	Fainting	**YES | NO**	Mitral Valve Prolapse	**YES | NO**
Artificial joint/heart valve	**YES | NO**	Fatigue	**YES | NO**	Pacemaker	**YES | NO**
Asthma	**YES | NO**	GERD	**YES | NO**	Radiation therapy	**YES | NO**
Acid Reflux	**YES | NO**	Headaches	**YES | NO**	Respiratory Disease	**YES | NO**
Back problems	**YES | NO**	Heart attack	**YES | NO**	Sleep Apnea	**YES | NO**
Blood disease	**YES | NO**	Heart Murmur	**YES | NO**	Stroke	**YES | NO**
Chemical dependency	**YES | NO**	Hemophilia	**YES | NO**	Thyroid Problems	**YES | NO**
Glaucoma	**YES | NO**	Hepatitis	**YES | NO**	Tuberculosis	**YES | NO**
Chemotherapy	**YES | NO**	High blood pressure	**YES | NO**	Ulcer	**YES | NO**
Cancer	**YES | NO**	HIV/AIDS	**YES | NO**	Depression	**YES | NO**

Have you had any serious type of illness or operation? _____ If Yes describe: _____

If you have a disease, condition or problem not previously listed, please describe: _____

_____

Have you ever taken Fosamax, Boniva, Actonel, or any other cancer medications? **YES | NO**

Do you use tobacco? **YES | NO** Has your Doctor ever told you that you require a Pre-Medication? **YES | NO**

(Women) Are you currently pregnant or trying to? **YES | NO** Nursing? **YES | NO**

Please list any/all medications you are currently taking; _____

_____

_____

Patient name (Printed) _____ Signature_____

DDS signature _____ Date ____/____/_____

FINANCIAL POLICY

Thank you for choosing Icon Dental Center as your dental health care provider. We are committed to providing the best dental care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your treatment.

- Please provide accurate and complete personal and insurance information prior to being seen by the dentist.
- All applicable co-pays, personal balances, both current and prior, are due at the time of service or upon receipt of invoice.
- We accept Cash, Check, Visa, Master card, Discover, Care credit and Health savings account cards.

Regarding your Dental Insurance

We participate in most insurance plans, however we require that the guarantor, the person who is financially responsible, is *personally* liable for all balances not covered by insurance. It is your responsibility to understand your dental benefits. Please be aware that some and perhaps all of the services provided may be non-covered services or may not be considered dentally necessary under your dental insurance. Please understand that insurance is always an estimate and never guarantee of coverage. Final determination will be made when the claim is received and processed by your insurance. We will file all insurance claims with the insurance provider you supply our office with. Please be sure to update our office of any changes in your insurance. Please also remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. Your insurance company may need you to supply certain information directly in order to pay the claim. If you are uncertain about your current insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket expenses and, coverage limits.
Initials: _____

Cost of Treatment

Treatment plans are customized for your individual care. To that end we want you to be aware of your financial investment into your care and do so by providing *estimates* of your out-of-pocket expenses based upon your plan. Please understand that any estimate given is just an estimation of costs as there are many factors that contribute to the treatment and insurance coverage. *Initials*: _____

Missed appointments

To provide the best care possible for each patient, Icon dental center requires a 48 hours business day notice for any cancelations or changes, to avoid a charge. Appointments that are missed or canceled without notice will be assessed with a $100.00 per hour scheduled, fee. *Initials:* _____

Minors

The parent(s), guardian(s), or Financial Guarantors is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors. *Initials*: _____

Past Due Accounts

I/We agree to pay all attorney's fees, court costs, and filing fees, which may be assessed by any collection agency or law firm retained to pursue the matter. Additionally, past due balances shall accrue interest at the rate of twelve (12%) percent per annum.
Initials: _____

Address Changes

It is our policy to provide invoices for any amounts owed on your account. We send all correspondence to the address information you provide, so please advise us anytime there is a change to your address, telephone number or other contact information.

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a $25.00 fee.

I authorize Icon Dental Center to release pertinent dental/medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits to be paid directly to Icon Dental Center.

I have read the Financial Policy. I understand and agree to the Financial Policy.

Financial Guarantor- Printed Name _____ Signature _____

Date _____/_____/_____

PRIVACY POLICY – ACKNOWLEDGEMENT OF RECEIPT

I certify that I have received a copy of Icon Dental Center Notice of Privacy Practice. The Notice of Privacy describes the types of uses and disclosures of my protested health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices also describes my rights and Icon Dental Center's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the facility.

Icon Dental Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice at the time of my first visit after the revisions become effective. I may also obtain a revised Notice by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

I hereby specifically authorize disclosure of my protected health care information to the persons indicated below; this may include appointment information, insurance and sensitive personal information to;

Any member of my immediate family	**YES | NO**
Spouse Only	**YES | NO**
Other (Specify) _____	**YES | NO**

Patient name (Printed) _____ Signature _____

Date ____/____/_____