Check In:

COLLINS DENTAL

Final Review:

BP_____

Although dental professionals primarily treat the area in your mouth, 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 confidential questions.

Patient Information Date_____

Patient Name_____ D.O. B _____

Nickname_____ Male or Female Single / Married / Divorced / Widowed SS# _____

Your Address_____ City_____ St_____ Zip_____

Home#_____ Cell#_____ Work#_____

Email_____

Emergency Contact_____ Relationship_____ Phone#_____

Are You A Student? Yes No Where? _____ Full / Part Time

Who Can We Thank for Referring You? _____

Dental Insurance Information

Insured's Name_____ D.O.B_____ Relationship to Patient_____

Ins Company _____ Ins Phone #_____ I.D#_____

Employer _____ Group#_____ Insured's SS#_____

Medical Health

Physician: _____ Phone#_____ Last Physical Exam_____/_____/____

General Health: Excellent___ Good___ Fair___ Poor___

Have you had any serious illness, operation, complication, been hospitalized in the past 5 years? No Yes, please explain:

_____

Are You Taking Medications? (If So What?) _____

_____

Are You Allergic To: Penicillin ___ Latex ___ Local Anesthetics ___ Codeine ___ Sulfa ___ None ___

Any Other Allergies? _____

Do You Have Any Dental Concerns? NO YES: _____

Women: Are You Pregnant or Think You May Be Pregnant? Yes No Trimester? 1 2 3 Nursing? Yes No

Indicate Which of The Following You Have Had or Have at Present. Circle Yes or No and Circle Options.

Abnormal Bleeding	YES	NO
AIDS/HIV Positive	YES	NO
Alzheimer's/Dementia	YES	NO
Anemia	YES	NO
Arthritis/Rheumatoid	YES	NO
Asthma	YES	NO
Blood Disease	YES	NO
Blood Thinners	YES	NO
Cancer	YES	NO
Chemotherapy	YES	NO
Convulsions/ Seizures	YES	NO
Digestive Disease	YES	NO
Diabetes Type 1 or 2?	YES	NO
Excessive Bleeding	YES	NO
Epilepsy	YES	NO

Head Injuries	YES	NO
Hearing Impaired	YES	NO
Heart Disease	YES	NO
Heart Pacemaker	YES	NO
Heart Stent/Shunt	YES	NO
Heart Valve Replacement	YES	NO
Hepatitis*	YES	NO
*Type: A, B, C, D, E, F, G?		
Herpes	YES	NO
High or Low Blood Pressure	YES	NO
Infective Endocarditis	YES	NO
Kidney Disease	YES	NO
Mitral Valve Prolapse	YES	NO
Multiple Sclerosis	YES	NO
Neck/Back Problems	YES	NO

Nervous Disorders	YES	NO
Osteoporosis	YES	NO
Bisphosphonates *IV/Oral?	YES	NO
Parkinson's Disease	YES	NO
Prosthetic Joints*	YES	NO
*where/when?		
Radiation Treatment	YES	NO
Sinus Problems	YES	NO
Smoke/Chew Tobacco	YES	NO
Sleep Apnea/ CPAP	YES	NO
Steroid Use	YES	NO
Thyroid Disease	YES	NO
Ulcers	YES	NO
Vape Smoker	YES	NO
Other:		

***For Parents of Minors: By Signing below, you are agreeing to be responsible Guardian for the minor's account and balances.**

Patient/Guardian Signature_____ **Date** _____

_____

Doctor Signature **Date**

COLLINS DENTAL

Your Dental Story

Gums Bleed While Brushing	YES	NO
Problems with Bad Breath	YES	NO
Sensitivity to Hot/Cold	YES	NO
Grind/Clench Teeth	YES	NO
Frequent Headaches	YES	NO
Clicking/Popping When Chewing	YES	NO
Snore	YES	NO

To understand what's going on in my mouth, my preference is:	
	To know / discuss all the details
	To be shown pictures and videos
	To read pamphlets and brochures

When I think about coming to the dentist I feel:	
	Comfortable – I have no anxiety. My past experiences have been pain free.
	Anxious – I make myself come but am somewhat uncomfortable.
	Fearful – I've stayed away because my past experiences have been traumatic & only come when necessary.
	Extremely fearful – I have avoided the dentist for many years to the detriment of my dental health.

On a scale of 1-10 (10 being the most) how happy are you with your smile?

 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 

I Have A Fear or Concern About:	
	Not Being Numb
	Being Numb
	Needles
	Gagging
	Loss of Control
	Being Scolded
	Made to Feel Ashamed
	Losing My Teeth
	Catching A Disease
	Cost of Treatment
	Sounds of The Dental Drill
	Waiting
	Other:

If I could change something about my smile, it would be:	
	Whiter
	Straighter
	Healthier
	Close spaces
	Do you have a gummy smile?
	Repair chipped teeth
	Replace missing teeth
	Replace crowns that don't match
	Replace old fillings

COLLINS DENTAL

Notice to Our Patients

Handling of Your Insurance

So that you can be clear on how our office handles dental insurance, we wanted to share the following information with you:

Our diagnosis and treatment recommendations for you are based on what is best for your oral health and not based on what your dental insurance plan will cover or will not cover. Your benefits are related to the type of plan chosen by you and your employer. We are not a part of this contract. Often these benefits are not structured to cover the total cost of dental treatment. We will work with you and your primary insurance to get you maximum benefits and provide financial arrangements to allow you to receive your care.

As a courtesy, Collins Dental will bill your insurance company. Should a patient have secondary insurance, we will file with the insurance company; however, it is never a guarantee that the insurance company will make a payment.

If we do not hear from your insurance company within 60 days of billing, the balance will become your responsibility and it is to be paid in full. The responsibility will become yours to collect the reimbursement from your insurance company. A finance charge of 1.5 % will incur at 90 days.

My healthcare information may be disclosed to Collins Dental for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Cancellation and Broken Appointment Policy

When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We ask that if you must change an appointment, please give us as least **48 BUSINESS HOURS** notice. This courtesy makes it possible to give your reserved room to another patient who would like it. A charge of $75 will be charged if you do not show up for your scheduled appointment or for repeated cancellations without 48-hour notice.

Repeated cancellations or missed appointments may result in loss of future appointment privileges as well. We feel that our patient's time is valuable.

Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Our goal is to deliver exceptional care for you and your family in a timely manner, and we appreciate your cooperation by honoring your scheduled appointment times.

Please sign that you have read and understand the above guidelines.

Printed Patient Name _____

Patient Signature _____ Date_____

COLLINS DENTAL

Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agent embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine, for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received within 30 days treatment is completed, I understand that a 1.5% late charge may be added to my account.

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office. The practice provides this information for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Messages, Mail, Wireless Calls and Texting:

I understand you may communicate with me through US Mail, electronic mail, telephone or voice mail messages, to remind me about my appointments, or treatment follow-up. Voice mail messages may contain specific appointment information. I understand that I must tell you if I do not want you to communicate with me like this. I agree and have initialed below for Collins Dental to use an automated telephone dialing system, and texting, to contact the cellular telephone number(s) that I provided for appointment, treatment, and payment purposes.

Initial_____

For the safety and security of FH Collins III DDS PA dba Collins Dental, team members and patients, I understand that I may be videoed in either the practice parking lot or in conspicuous/obvious-public places within the dental office.

Initial_____

I acknowledge and understand that:

- My Protected Health Information may be disclosed and used for treatment planning and decisions, securing payment from third party payers, and/or assessing quality and reviewing the competence of healthcare operations.
- I may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I wish to place the following restrictions on disclosure of my health information: _____

I give permission to *Collins Dental* to discuss my Protected Health Information with the following individuals:

Name	Relationship	Name	Relationship

I acknowledge that a copy of the *Collins Dental Notice of Privacy Practices*, which contains a more complete description of information uses and disclosures, has been made available to me and I have been given the opportunity to ask any questions that I may have regarding this notice. My consent will terminate on the last day I am seen in this office for treatment.

_____

Patient/ Legal Guardian- Signature Date