Village Dental
COSMETIC & GENERAL DENTISTRY

## Welcome to our Family!

We are committed to providing exceptional dental care in a compassionate and professional environment. The following information is provided to introduce you to our practice policies. We are happy to address any questions or concerns you may have. ***Please keep this page for your reference.***

## Appointments

We make every effort to honor your time commitment and, appreciate being extended the same courtesy. You will be reminded of your appointment(s) in advance via text, call, or email. If you would like to receive only one type of reminder (e.g. no texting, email only), please notify us so we are able to accommodate you.

## Continuing Care

We are focused on preventive care and maintaining optimum oral health for our patients. We recommend comprehensive treatment and continuing care on an appropriate recall schedule. A treatment plan and hygiene recall schedule specific to your needs will be provided to you at the time of your appointment.

## Care After-Hours

We accommodate patients of record who experience dental emergencies after hours. A patient of record is one who has been seen and treated in our office during the past 18 months. If you are a patient of record and have a dental emergency, please leave a message on our emergency voicemail line.

## Children & Adolescents

We are happy to treat children who can behave appropriately during their visit. One parent/guardian is welcome to accompany the child in the operatory. If under age 18, a parent/guardian must remain on the premises for the duration of the appointment. Please ask us about scheduling a pre-treatment appointment to familiarize your child with our office and the procedure to be completed, if desired.

## Cancellations and Missed Appointments

We strive to honor our time commitment to you and allow all our patients to be seen at their most convenient time. ***48 hours advanced notice is required to cancel or reschedule any appointment***. If you are not able to provide adequate notice to cancel or reschedule, a fee will be charged to your account.

## Payments and Insurance

It is our goal to assist all our patients in obtaining the dental treatment they deserve. Payment for treatment is due the day services are rendered, regardless of insurance coverage. We accept several payment options, including cash, check, major credit cards, and CareCredit. Dental insurance will be billed as a courtesy once treatment is completed. Please do not hesitate to reach out if you require additional financial assistance.

Village Dental
COSMETIC & GENERAL DENTISTRY

## Patient Information

Name: _____ Preferred Name: _____

Date of Birth: ____ / ____ / _____ SSN#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Mobile #: _____ Work #: _____ Home #: _____

Email Address: _____

Family Status: Single / Married / Child Spouse's Name: _____

How did you find our practice? Google / Post Card / Facebook / Yelp / Insurance / Family / Friend

Who can we thank for referring you? _____

## Person Responsible for Account (*If different from patient*)

Name of Responsible Party: _____

Date of Birth: ___ / ___ / ___ SSN#: _____

Relationship to Patient: Self / Spouse / Parent / Other: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Mobile #: _____ Work #: _____ Home #: _____

Email Address: _____

## Contact Information

What is the best way to communicate with you? Call Home / Call Mobile / Business Phone / Text / Email

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone #: _____

Village Dental
COSMETIC & GENERAL DENTISTRY

## Dental Insurance Information (Primary)

Subscriber: _____ Relationship to Patient: Self / Spouse / Parent/ Other: _____

Subscriber's Date of Birth: ___ / ___ / ____ Subscriber's Employer: _____

Carrier Name: _____ Phone # (found on back of card): _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Plan ID #: _____ Plan Group #: _____

## Dental Insurance Information (Secondary)

Subscriber: _____ Relationship to Patient: Self / Spouse /Parent/Other: _____

Subscriber's Date of Birth: ___ / ___ / ____ Subscriber's Employer: _____

Carrier Name: _____ Phone # (found on back of card): _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Plan ID #: _____ Plan Group #: _____

## Employment Information

Employer Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

## Cancellations and Missed Appointments

48 hours advanced notice is required to cancel or reschedule any appointment. If you are not able to provide adequate notice to cancel or reschedule, a fee will be charged to your account. Patients who fail to present for multiple appointments may be dismissed from the practice. **By signing below, you acknowledge that you have read, understand, *and* agree to this policy.**

Signature: _____ Date: _____

Village Dental
COSMETIC & GENERAL DENTISTRY

# Medical History

1. Have you ever been hospitalized for any surgical operation/serious illness? Yes / No
   a. If yes, please explain: _____
   _____

2. Are you under any medical treatment now? Yes / No
   a. If yes, please explain: _____
   _____

3. Have you ever experienced excessive bleeding requiring special treatment? Yes / No

4. **WOMEN** please mark if you are:
   ☐ Pregnant ☐ Trying to get pregnant ☐ Breast Feeding

5. Are you allergic to *or* have you had an allergic reaction to any of the following?

| | | |
|---|---|---|
| ☐ Acrylic | ☐ Erythromycin | ☐ Penicillin |
| ☐ Aspirin | ☐ Iodine | ☐ Sedatives |
| ☐ Barbiturates | ☐ Latex | ☐ Sulfa |
| ☐ Codeine | ☐ Local Anesthetics | ☐ Other _____ |
| ☐ Drugs | ☐ Metals | |

6. Have you been told to pre-medicate with antibiotics prior to a dental appointment? Yes / No

7. Have you previously taken bisphosphonates (e.g. Fosamax)? Yes / No

8. Please list any medications you are currently taking (a list may be attached instead):
   _____

Village Dental
COSMETIC & GENERAL DENTISTRY

## Medical History (continued)

Have you ever experienced any of the following? (*Select those that apply*)

- ☐ Alcoholism
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Implant
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac Pacemaker
- ☐ Chest Pains
- ☐ Cold Sore
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Failure/Attack
- ☐ Heart Murmur
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV+, AIDS, STDs
- ☐ Hives/Skin Rash
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Disorder
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorder
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Respiratory Problem
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Problem
- ☐ Stent
- ☐ Steroid Treatment
- ☐ Stomach Problem
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tobacco Use
- ☐ Transplant
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Other _____

**By signing below, I acknowledge the importance of a truthful medical history and realize that incomplete information may have an adverse effect on my dental treatment and overall health. To the best of my knowledge, the information above is complete and accurate.**

Signature: _____ Date: _____

Village Dental
COSMETIC & GENERAL DENTISTRY

# Dental History

Previous Dental office: _____

Date of last dental exam: _____ Date of last dental x-rays: _____

Are you having tooth or gum pain at this time? Yes / No

Do you feel nervous about having dental treatment? Yes / No

Have you ever had a negative experience in a dental office? Yes / No

Do your gums bleed when flossing / brushing? Yes / No

Have you ever seen a periodontist? Yes / No

Have you ever had a Scaling & Root Planing treatment ("deep cleaning") Yes / No

Is there anything you would like addressed during your appointment? Yes / No

If yes, please specify: _____

**Do you have any of the following dental concerns** (*select any that apply*)

- ☐ Bad Breath
- ☐ Bad Taste in Mouth
- ☐ Bleeding Gums
- ☐ Clenching
- ☐ Difficulty Chewing
- ☐ Difficulty Closing
- ☐ Difficulty Opening
- ☐ Food Catching
- ☐ Grinding
- ☐ Hot/Cold Sensitivity
- ☐ Jaw Clicking
- ☐ Pain in/around Ears
- ☐ Pressure Sensitivity
- ☐ Swelling
- ☐ TMJ/TMD Diagnosis
- ☐ Tooth Pain
- ☐ Trauma to Face/Jaw
- ☐ Other _____

**By signing below, I acknowledge the importance of a truthful dental history and realize that incomplete information may have an adverse effect on my dental treatment and overall health. To the best of my knowledge, the information above is complete and accurate.**

Signature: _____ Date: _____

Village Dental
COSMETIC & GENERAL DENTISTRY

# Financial Agreement

*Please read carefully.*

We strive to assist our patients in completing their dental treatment to allow for optimal oral health. Payment for treatment is due the day services are rendered. Pre-payment arrangements can be made at any time, and our front office staff can address any inquiries in selecting the appropriate financial arrangement *before* your appointment date.

For your convenience, payment can be made via check, cash, major credit cards, and CareCredit. Unfortunately, ***we do not offer in-office payment plans.*** Our partnership with CareCredit, a medical-expense specific company, allows no-interest monthly financing options. Applications for CareCredit can be accessed in our office or online, and we would be happy to answer any questions that you may have.

As a courtesy, we will bill your dental insurance for services rendered. We participate in a Preferred Provider Organization (PPO), which is a contract between this office and the organization to provide dental services for a negotiated network fee. While we guarantee our fees will not exceed the network fee schedule, we are not responsible for variances in individual coverage and benefits with the PPO.

By signing below, you are acknowledging and agreeing to the following:

- My insurance plan is a contract between me, my employer, and my insurance company. Village Dental is not a party in my insurance contract.
- Treatment recommendations, and the dental services provided by Village Dental are in the best interest of my health and will not be determined based on my insurance coverage.
- Village Dental will do their best to provide me with an ***estimate*** of my co-payment, based on my coverage, although not all dental services may be covered under my insurance plan.
- It is my responsibility to read and understand my coverage, including preauthorization requirements, exclusions, termination dates, insurance provider, and waiting periods.
- I am responsible for the entirety of my bill, even if my insurance coverage is less than the provided ***estimated*** amount.
- I agree to pay the ***estimated*** co-payment at time of service. If a balance remains after payment from insurance is received, or if my insurance provider neglects to pay, I am responsible for the total balance of the services rendered.
- I am responsible for notifying Village Dental of changes to my insurance provider or policy.

Signature: _____ Date: _____

Village Dental
COSMETIC & GENERAL DENTISTRY

# Third Party Financial Service Agreement

*Please read carefully.*

We make every attempt to provide accurate information and estimations regarding treatment plan fees, insurance coverages, and co-payment amounts. Insurance claims for treatment procedures are submitted on or after the date that services are completed. Therefore, differences in co-payment amounts may vary from the estimated amount initially presented to you. We will make every attempt to notify you of differences in payments received, balances due, and payment options available in a timely manner. It is your responsibility to maintain current contact information so that we may do so. We utilize a third-party financial service agency (collection agency) ***after*** all contact methods have been exhausted with no acquisition of payment to your account.

1. I understand that if I do not pay my account with Village Dental in full that my account may be assigned to a collection agency for collection.
2. I understand that if my account is assigned to a collection agency that the collection agency will charge a commission or fee that may be as much as 50% of the amount I owe to Village Dental. I agree that if my account is assigned to a collection agency, that Village Dental may add the amount of the collection agency's commission or fee to the amount that I owe Village Dental, and I agree to pay the additional amount.
3. I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for dental services. I understand, for example, that if the unpaid balance that I owe to Village Dental is $1000 that Village Dental may add up to $500 to my account, and I agree to pay the sum of $1500 in such event.
4. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fee.

**By signing below, I acknowledge and accept the guidelines as outlined in the Financial Agreement.**

Signature: _____ Date: _____

Village Dental
COSMETIC & GENERAL DENTISTRY

# Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a notice of The Health Insurance Portability and Accountability Act (HIPAA) and our offices Notice of Privacy Practices. *Our Notice is available online.* If you prefer a paper copy, please as a member of our office to obtain a copy.

## Permission to Release Protected Health Information

I understand that my personal and health information is private, protected by Village Dental, and will not be shared with anyone without written consent. I give permission for the office of Village Dental to release my protected health information, such as: pending or completed treatment, insurance, medical history, account, and appointment information to other dental and health care professionals, ***and the following individuals***:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____