**Welcome To DAG!**

**Dental Arts Group (DAG) was founded on one simple premise: happiness. The happy experience starts with a smile, but a smile is so much more than a simple emotional act. At DAG, we feel that a smile has the power to change lives. It not only enhances our physical appearance, but has been scientifically proven to prolong and improve our lives. It is our goal to make your visit with us an extremely pleasant one and to send you home with a beautiful and healthy smile. We strive to make every patient feel just like a true member of our DAG family. Leading with compassion, integrity, and outstanding service. We welcome you to your new dental home. Thank you for completing all the required paperwork.**

**First Name** **Last Name** **MI** **Preferred Name**

**Gender Identity** **Birthday** **SSN**

☐ Same address for entire family

**Address** **Address ( con:)**

**City** **State** **Zip** **Home phone**

**Mobile** **Email**

**Marital status**

☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Legally Separated**

**Name of Employer**

**Employment Status**

☐ **Full time** ☐ **Part-time** ☐ **Retired** ☐ **Not Currently Employed**

**Emergency Contact Name**

**Emergency Contact Phone**

**Emergency Contact Relation**

**Welcome to your new dental home, may we ask why you are changing dentists?**

☐ Change of residence ☐ Change of dental plan ☐ Office is closer ☐ My dentist retired/closed

☐ Unhappy ☐ Too expensive ☐ You're recommended ☐ Other, comment below

**How long since your last visit to the dentist?**

☐ 1 month ☐ 3 months ☐ 6 months ☐ 1 year

☐ 2 years ☐ 3 years or more ☐ I've never been to the dentist

**How did you find us?**

☐ Other patient ☐ Referred by Doctor ☐ Yelp ☐ Google

☐ Social media ☐ Employee ☐ Insurance company ☐ Other/Comment below:

**Who may we thank for referring you?**

**Reason for today's visit:**

☐ Check-up ☐ Pain ☐ Consult ☐ Other/Comment below:

**Any further information that could help us solve any of your dental concerns?**

- **Have you ever had an unfavorable reaction to dental anesthetic?**
- **Does dental treatment make you nervous?**
- **Are your teeth sensitive to cold or hot?**
- **Do your gums bleed when you brush or floss?**

**What type of toothbrush bristle do you use?**

☐ Soft ☐ Medium ☐ Hard

**What type of toothbrush?**

☐ Electric ☐ Manual

**Are you aware of sores or irritated areas in your mouth?** ☐ Yes ☐ No

**Sleep Health Questionnaire (Check All That Apply):**

☐ You snore or have been told by someone that you snore
☐ You have been told that you stop breathing during your sleep
☐ You have awoken with a sensation of gasping or choking
☐ You often feel tired or fatigued immediately after getting up from sleep
☐ During your waking time, you often feel tired, fatigued or not up to par
☐ In the past 6 months, you've nodded off/fallen asleep that you didn't intend
☐ You have or are currently being treated for high blood pressure
☐ You currently wear a CPAP device

**Please indicate any of the following problems by checking off the corresponding box(es)**

- ☐ Discomfort, Clicking or Popping in Jaw
- ☐ Difficulty Closing Jaw
- ☐ Locking Jaw
- ☐ Ringing in Ears
- ☐ Blisters/sore in or arround mouth
- ☐ Food cought between teeth
- ☐ Swelling/lumps in mouth
- ☐ Lost/broken filling(s)
- ☐ Red, swollen or bleeding gums
- ☐ Difficulty opening jaw
- ☐ Bad breath
- ☐ Broken/chipped tooth
- ☐ Missing Teeth
- ☐ Recent infections
- ☐ Stained teeth
- ☐ Teeth grinding/clenching
- ☐ A removable dental appliance
- ☐ Loose/shifiting teeth
- ☐ Burning tongue/lips
- ☐ Toothache
- ☐ Other, comment below:

Have you ever been treated for periodontal disease?

Have you had braces (orthodontics)?

Have you had your wisdom teeth removed?

How often do you brush?

How often do you floss?

How would you rate your smile? (1= I dislike my smile, 10=I love my smile)

If you had a magic wand, What If anything would you change about your smile?

- ☐ Change the color of my teeth
- ☐ Change the shape of my teeth
- ☐ Close spaces or restore worn and broken teeth
- ☐ Change the position or alignment of my teeth
- ☐ Other:

**We respect that everyone has different goals for their teeth. Please check your TOP 2 priorities for your mouth and teeth.**

- ○ I want to keep my teeth and do only what is necessary to keep them
- ○ I want to stop any current pain and avoid any sudden future pain
- ○ I want to be able to chew and function more comfortably
- ○ I want to improve my oral health and prevent bad breath
- ○ I want to treat any current and/or prevent any future infections
- ○ I want to improve the look of my smile

**Please indicate any of the following interests by checking off the corresponding boxes:**

- ☐ Teeth whitening
- ☐ Straight teeth
- ☐ Getting my mouth healthier
- ☐ Esthetic evaluation
- ☐ Snoring/Sleep Apnea
- ☐ Breath control
- ☐ Replacement of missing teeth
- ☐ Learning how to care for mouth
- ☐ Other:

**Please check all medical conditions that apply:**

- ○ Allergies
- ○ Amoxicillin allergy
- ○ Anemia
- ○ Anti-Depressant
- ○ Arthritis
- ○ Takes aspirin
- ○ Asthma
- ○ Augmentin allergy
- ○ Birth control taking
- ○ Aspirin allergy
- ○ Blood thinner
- ○ By-Pass surgery
- ○ Cancer
- ○ COVID-19
- ○ Codeine allergy
- ○ Diabetes
- ○ Dizziness
- ○ Cipro allergy
- ○ Emphysema
- ○ Epilepsy
- ○ Erythromycin allergy
- ○ Ear trouble
- ○ Fainting
- ○ Glaucoma
- ○ Head injuries
- ○ Excessive bleeding
- ○ Heart disease
- ○ Heart murmur
- ○ Heart valve replacement
- ○ Hearing trouble
- ○ High blood pressure
- ○ HIV
- ○ Impaired vision
- ○ Hepatitis
- ○ Low blood pressure
- ○ Kidney disease
- ○ Latex allergy
- ○ Jaundice
- ○ Joint replacement
- ○ Mental disorders
- ○ Metal allergy
- ○ Liver disease
- ○ Lupus
- ○ NO EPI (Novocaine)
- ○ Pace maker
- ○ Mitral valve prolaps
- ○ Nervous disorders
- ○ Pregnancy
- ○ Pre-medication
- ○ Panic attacks
- ○ Penicillin allergy
- ○ Rheumatic fever
- ○ Seizures
- ○ Radiation treatment
- ○ Respiratory problems
- ○ Tuberculosis
- ○ Tumors
- ○ Sinus problems
- ○ Stroke
- ○ Zithromax allergy
- ○ Thyroid
- ○ Ulcers

**Please elaborate on any/all medical conditions listed or not:**

**Are you allergic to any of the following?**

- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Metals
- ☐ Dental Anesthetics
- ☐ Food Allergies
- ☐ Nut Allergy
- ☐ Other:

**Are you taking any medications at this time?** ☐ YES ☐ NO

**If yes please list all medications(prescribed and non-prescribed)**

**Have you been admitted to a hospital in the last two years? If yes, explain please:**

**Do you smoke cigarettes, cigars, marijuana, vape?** ☐ YES ☐ NO

**If yes, how often (amount per day and how long have you smoked?)**

**Primary medical physician and location:**

**Date of last medical physican visit**

**Have you ever been told to pre-medicate or take antibiotics before seeing a dentist?** ☐ YES ☐ NO

**Have you had any of the following (CIRCLE) Joint Replacement, Heart Valve Replacement, Endocarditis?**

**IF YES: What joint/valve? When was surgery?**

**Have you been treated for osteoporosis (bone loss)?** ☐ YES ☐ NO

**IF YES: What medication?**

| | |
|---|---|
| **Women: Are you pregnant?** | |
| **If yes, Due date?** | |
| **Do you take birth control medications?** | |
| **Are you nursing?** | |

**To ensure that your visit with us is a great experience, please share any questions or concerns that you would like us to know about.**

**Patient signature**

**Date**

## HIPAA OMNIBUS RULE
## PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
## CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

**Date:** **Patient Name :**

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA ?

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents,grandparents and any care takers who can have access to this patients records)

**Name:** _____ **Relationship:** _____

**Name:** _____ **Relationship:** _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS,TREATMENT& BILLING INFORMATION VIA:

Phone Confirmation

☐ Message to my cell phone
☐ Home phone confirmation
☐ Email confirmation
☐ Work phone confirmation
☐ Any of the above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO** on behalf of this HEALTH CARE facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ Any of the above
☐ None of the above(opt out)

In signing this HIPAA patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health.This office may or may not receive third party remuneration from these affliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The Undersigned acknowledges receipt of a copy of the currently effective notice of privacy practices for this healthcare facility. A copy of this signed, dated document shall be so effective as the original.
**My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor/facilities in the future.**

_____ _____

Please print name of patient Please sign patient/Guardian of patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

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OFFICE USE ONLY

As privacy officer, I attempted to obtain the patient's(or representatives) signature on this Acknowledgement but did not because:

☐ It was emergency treatment
☐ I could not communicate with the patient
☐ The patient refused to sign because
☐ Other(please describe) _____

_____

Signature of privacy officer _____

Will you be using insurance? ◯ Yes ◯ No (If No skip this section)

## Primary Insurance Information

Insured's First Name | Insured's Last Name | Insured's Birthdate

Insurance carrier

ID Number | Group Number

Insured's Address

Address 1

City | State/Province | Zip/Postal Code

Insured's Employer Name

Employer's Address

City | State/Province | Zip/Postal Code

Patient's relationship to insured

◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Address (Back of card)

Address 1

City | State/Province | Zip/Postal Code

Insurance Phone Number

By signing below,I authorize my Insurance company to pay the dentist all insurance benefits rendered.I authorize the use of this electronic signature on all insurance submissions.I authorize the dentist to release all information necessary to secure the payment of benefits.I understand that I am financially responsible for all charges whether or not paid by insurance.I understand the above information and agree with its contents, and my name and date below will serve as my electronic signature for this form.

Signature: Date:

Do you have Secondary Dental Insurance?If yes, please complate the following

○ Yes ○ No (If You Do Not Have Dual Insurance Coverage, Please Disregard This Section)

## Secondary Insurance Coverage

Insured's First Name | Insured's Last Name | Insured's Birthdate

ID Number | Group Number

Insured's Address

Address 1

City | State/Province | Zip/Postal Code

Insured's Employer Name

Employer's Address

City | State/Province | Zip/Postal Code

Patient's relationship to insured

○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Carrier

Insurance Address (Back of card)

Address 1

City | State/Province | Zip/Postal Code

By signing below,I authorize my Insurance company to pay the dentist all insurance benefits rendered.I authorize the use of this electronic signature on all insurance submissions.I authorize the dentist to release all information necessary to secure the payment of benefits.I understand that I am financially responsible for all charges whether or not paid by insurance.I understand the above information and agree with its contents, and my name and date below will serve as my electronic signature for this form.

Signature: Date:

# FINANCIAL AND SCHEDULING POLICIES

Thank you for allowing Dental Arts Group (DAG) the opportunity to care for your lifetime dental needs. We are excited to partner with you to improve and maintain your oral health. We will be sensitive to your financial and scheduling circumstances and do everything possible to help you achieve optimal oral health. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. We ask that there is a clear understanding as outlined below of our financial and scheduling policies. Thank you!

## Financial Guidelines:

- Payment in full is due at the time of service. This would include estimated deductible, co-pays, and co-insurances. The patient is responsible for all charges regardless of insurance coverage.
- For your convenience, treatment costs can be paid for with cash, credit card, check, or third party financing. A minimum of $10.00 is required for all credit card transactions.
- Statements will be mailed on a monthly basis. Accounts unpaid after 30 days from the billing date will be subject to a finance charge. In special cases of hardship, or for unusually high balances, a payment plan may be discussed with the office manager.
- Account balances over 90 days are subject to $35 late fee . If your account is referred to collections, you will be responsible for an administrative fee/collection cost in the amount of 40% of the outstanding balance, which will be added to the balance due. In addition, court costs and reasonable attorney fees will also be applied if your account is referred to small claims court.
- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are rendered.

## Patients with Insurance:

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit. We will bill your insurance directly to collect reimbursement for your treatment so that you will receive the full benefits of insurance coverage. At DAG, we strive to maximize your insurance benefits and help to make any remaining balance easily affordable. Please be advised that any amounts estimated to be paid by insurance providers are estimates only, and that no guarantee can be made by our office regarding these amounts. We will do all we can to ensure your estimate is as accurate as possible. However, insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums/limits which are your responsibility.

Regarding maximums, if you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. Please contact your insurance company for the detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan. In the event that the amount paid by your insurance(s) differs from the estimate, you will be billed for the outstanding balance.

All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of payment.

Insurance payments are ordinarily received within 30-60 days from service. If your insurance company has not made payment within 60 days, we may ask that you contact your insurance company to make sure payment is expected, at this time the remaining balance will be due and payable by you and you may be responsible for collection of your benefits directly from your insurance carrier. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. We will always make treatment recommendations based on individual needs and with regards to optimal oral health for our patients. It is our goal to provide our patients with the level of care that they desire and deserve, and we will not allow insurance plans to dictate the level of care we offer to our patients. We maintain that insurance is a method of payment, and not a method of treatment. Dental Arts Group does not render services on the assumption that our charges always be paid in full by an insurance company.

## Deposit Policy:

Certain appointments will require a deposit to reserve appointment time. Example appointments requiring a deposit may include those greater than 60 minutes, specialty surgeries, appointments seeing multiple providers, or certain high-demand appointment times will require a deposit of anticipated copay one week in advance to reserve appointment time. The remaining balances can be paid at the time of treatment.

## Minors:

Minors must be accompanied by the parent or legal guardian.The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. Treatment may be denied if signed treatment plans and financial arrangements are not made by the legal guardian.

## Missed Appointment(s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to prevent scheduling problems for our patients, we require at least a 24 hour notice for cancellations or for rescheduling your appointments. We understand that unforeseen circumstances may arise, which may result in changing or missing your appointment (though we would prefer 48-hour notice when possible). If you miss a scheduled appointment or cancel with less than 24 hr notice, a warning will be issued. A second missed or canceled appointment less 24-hour notice will incur a charge of $25/hr for a hygiene visit, $50/hr for a doctor visit, $100/hr for a specialist visit. Please help us care for you better by keeping scheduled appointments.

## Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Signature: _____ Date: _____