Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. #_____
Last name First Name Initial
Address_____
City_____ State _____ Zip_____ Home Phone_____
Cell Phone _____ Email_____
Sex □ M □ F Age _____ Birthdate_____ □ Single □ Married □ Widowed □ Separated □ Divorced
Patient Employed by _____ Occupation_____
Business Address_____ Business Phone_____
Whom may we thank for referring you?_____
Notify in case of emergency_____ Phone_____
Driver's License #_____

Responsible Party (If different than patient)

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient_____ Birthdate_____ Soc. Sec. # _____
Address (if different from patient) _____ Home Phone_____
City_____ State_____ Zip _____
Cell Phone_____ Email_____
Person Responsible Employed by _____ Occupation_____
Business Address _____ Business Phone_____
Email _____

Primary Dental Insurance

Subscriber Name_____ Relation to Patient_____ Birthdate_____
Employers Name_____ Insurance Company_____
Insurance Company # _____
Subscriber # _____ Group # _____
Name of other dependents under this plan_____

Secondary Dental Insurance

Subscriber Name_____ Relation to Patient_____ Birthdate_____
Employers Name_____ Insurance Company_____
Insurance Company # _____
Subscriber # _____ Group # _____
Name of other dependents under this plan_____

Dental History

What would you like us to do today? _____
Are you in dental discomfort today? _____
Former Dentist _____ Phone_____
Date of last dental care_____ Date of last x-rays? _____
Check (√) yes or no if you have had problems with any of the following:

☐Y ☐ N Bad breath ☐Y ☐ N Food collection between teeth ☐Y ☐ N Periodontal treatment ☐Y ☐ N Sensitivity to sweets
☐Y ☐ N Bleeding gums ☐Y ☐ N Grinding or clenching teeth ☐Y ☐ N Sensitivity to cold ☐Y ☐ N Sensitivity when biting
☐Y ☐ N Clicking or popping jaw ☐Y ☐ N Loose teeth or broken fillings ☐Y ☐ N Sensitivity to hot ☐Y ☐ N Mouth Sores/Growths

How often do you brush?_____ Floss?_____
How do you feel about the appearance of your teeth?_____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐ N
Other information about your dental health or previous treatment_____

Medical History

Physician's name_____ Phone_____
Date of last visit_____ Have you had any serious illness or operations? ☐Y ☐ N
If yes, describe_____
Are you currently under physician care? ☐Y ☐ N If yes, describe_____
Women: Are your pregnant? ☐Y ☐ N Nursing? ☐Y ☐ N Taking birth control pills? ☐Y ☐ N
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Y ☐ N
Check (√) yes or no whether you have had any of the following:

☐Y ☐ N AIDS/HIV Positive
☐Y ☐ N Anaphylaxis
☐Y ☐ N Anemia
☐Y ☐ N Arthritis, Rheumatism
☐Y ☐ N Artificial heart valves
☐Y ☐ N Artificial joints
☐Y ☐ N Asthma
☐Y ☐ N Back problems
☐Y ☐ N Blood disease
☐Y ☐ N Cancer _____(type)
☐Y ☐ N Chemical dependency
☐Y ☐ N Chemotherapy
☐Y ☐ N Circulatory problems
☐Y ☐ N Cortisone treatments
☐Y ☐ N Cough, persistent
☐Y ☐ N Cough up blood
☐Y ☐ N Diabetes
☐Y ☐ N Seizures
☐Y ☐ N Fainting
☐Y ☐ N Food allergies
☐Y ☐ N Glaucoma
☐Y ☐ N Headaches
☐Y ☐ N Heart murmur
☐Y ☐ N Heart problems/Surgeries
Describe _____
☐Y ☐ N Abnormal bleeding
☐Y ☐ N Herpes
☐Y ☐ N Hepatitis ____ (type)
☐Y ☐ N High blood pressure
☐Y ☐ N Jaw pain
☐Y ☐ N Kidney disease
☐Y ☐ N Liver disease
☐Y ☐ N Material allergies (Latex, etc)
Type:_____
☐Y ☐ N Nervous problems
☐Y ☐ N Psychiatric care
☐Y ☐ N Rapid weight gain or loss
☐Y ☐ N Tuberculosis
☐Y ☐ N Radiation treatment
☐Y ☐ N Respiratory disease
☐Y ☐ N Rheumatic/ Scarlet fever
☐Y ☐ N Shortness of breath
☐Y ☐ N Skin rash
☐Y ☐ N Stroke
☐Y ☐ N Surgical implant
☐Y ☐ N Swelling of feet or ankles
☐Y ☐ N Thyroid disease
☐Y ☐ N Tobacco habit
☐Y ☐ N Other: _____
_____
_____

Is patient currently taking any medications? ☐Y ☐ N If yes, list all:
_____
_____

Does patient have drug allergies? ☐Y ☐ N If yes, list all:
_____
_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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 responsible for all charges whether or not paid by insurance.

Signature _____ Date:_____

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST CARE POSSIBLE. YOUR CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY, OR YOUR RESPONSIBILITY.

1. ALL patients must complete our "Patient information Form" before seeing the Doctor.
2. **Full payment is due at time of service** unless you have insurance, then difference of balance and EIP (estimated insurance payment) is due at time of service. We offer in-house payment plans on a case-by-case basis, if requested.
3. We accept Cash, Checks, Visa, Discover, MasterCard, American Express, and CareCredit.
4. We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with Cash or Check prior to completion of care.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits.

We will file insurance on your first visit IF you can provide us with **ALL** insurance information including an 800 number to verify your coverage. If your insurance company has not paid the **FULL BALANCE within 45 days**, you will have 15 days to pay the balance. If your insurance company pays more than the balance due, we will either send a refund check to you or credit your account, which ever you prefer.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY

We are NOT party to this contract, in most cases. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists.) We file insurance claims as a **courtesy** to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, covered charges, secondary insurance, "usual and customary" charges etc…other than to supply factual information as necessary. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.**

The attached detailed medical history is for your protection. It is designed to prevent interactions with the medications for your treatment. If you elect to omit pertinent medical information including but not limited to medications, allergies, high blood pressure, heart condition, heart murmur, rheumatic fever, artificial joint, surgery, pregnancy, illicit drug use, i.e. (cocaine, alcoholism, etc.). Be aware that you may be placing yourself at undue risk of complications including death.

I give Dr. Eric Loper, D.D.S., PC permission to provide standard dental care as the doctor, and I deem necessary and feasible to maintain and restore to a state of optimum dental health my dentition (to fix my teeth) as well as possible, considering all known factors i.e. money, time, condition of teeth and physical health.

POSSIBLE COMPLICATIONS, INCLUDING BUT NOT LIMITED TO: (1) All dental procedures, including local anesthesia administration: Pain, swelling, TMJ problems, bruising, cracked lips, swallowing, infection. (2) Exam: Missed cavities, cracked lips. (3) Prophy (Cleaning): Sore or bleeding gums, sensitive teeth, cut cheek or tongue. (4) Fillings and Crowns: Sensitivity to hot or cold, throbbing, possible root canal, recurrent decay, pulp exposure, sore gums, high spot. (5) Root Canals/Pulpotomies: Failure of root canal, short fill, long fill, broken files, perforation. (6) Extractions/Surgery (pulling teeth): Nerve damage, opening sinus cavity, fractured jaw, cut blood vessels, root tips left, dry socket, breaking of other teeth. (7) Partials/Dentures: Sore spots, yeast infections, shifting teeth, broken clasps, extra bone shrinkage. (8) Bleaching: Sensitive teeth, failure, root canal treatment.

I have read and understand the information listed above.

DATE: _____ SIGNATURE:_____

Dr. Eric Loper, D.D.S., PC
CONSENT FOR DISCLOSURE OF PROTECTED
HEALTH CARE INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person
listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Signature_____ **Date**_____