



In order to serve you properly, we will require the following information. All information is strictly confidential. (Please Fill out Completely)

Patient's Name: _____
Last First MI

Social Security: _____ Sex: (M) (F) Date of Birth: _____
MM/DD/YYYY

Reason for todays visit? _____

Please indicate who you would like to see: ____Dentist ____Orthodontist ____Both

How did you hear about our office(Circle all that apply)?

Google, Yelp, Instagram, Facebook, Youtube, Pinterest, Friend, Family, Insurance carrier

Did anyone specifically refer you? (Yes/No) Name of referral: _____

Responsible Party Information:

Name: _____ Marital Status: _____
Last First MI

Address: _____ APT# _____

City: _____ State: _____ Zip Code: _____

Ph: _____ Email: _____ Work: _____

Date of Birth: _____ Relationship to Patient: _____
MM/DD/YYYY

Insurance Information:

Name of the primary account holder: _____

Relationship to the subscriber? ____ Self ____Spouse ____Child

Name of the insurance company: _____ Employer Name: _____

Subscriber/Member I.D.: _____ D.O.B. of Account Holder: _____

Insurance phone number: _____ Group number: _____

Policy holders name for **secondary insurance** (if applicable): _____

Relationship to the subscriber? ____ Self ____Spouse ____Child

Name of the insurance company: _____ Employer Name: _____

Subscriber/Member I.D.: _____ D.O.B. of Account Holder: _____

Insurance phone number: _____ Group number: _____

Emergency Contact Name: _____ Ph: _____



Medical History

List all medications/vitamins/supplements that you are now taking:

Are you allergic to any of the following?

Y N

☐ ☐ Anesthetic

☐ ☐ Aspirin

☐ ☐ Codeine

☐ ☐ Ibuprofen

Other: _____

Y N

☐ ☐ Iodine

☐ ☐ Latex

☐ ☐ Penicillin

☐ ☐ Sulfa Drugs

Do you have any of the following medical conditions?

Y N

☐ ☐ Asthma

☐ ☐ Bleeding Problems

☐ ☐ Cancer

☐ ☐ Diabetes

☐ ☐ Heart Murmur

☐ ☐ Heart Trouble

☐ ☐ High Blood Pressure

☐ ☐ Joint Replacement

Other: _____

Y N

☐ ☐ Kidney Disease

☐ ☐ Liver Disease

☐ ☐ Pregnancy

☐ ☐ Psychiatric Treatment

☐ ☐ Sinus Trouble

☐ ☐ Stroke

☐ ☐ Ulcers

☐ ☐ Rheumatic Fever

Tobacco use? If so, what kind and how much? _____

Are you currently seeing a physician? (Yes/No)

Name and address of physician: _____

Dental History

What would you like to change about your smile? (ex: Do you want more white, straight, healthy teeth or veneers?) _____

When was the patient's last visit to the dentist? _____ Month(s) _____ Year(s)

Has the patient ever seen an Orthodontist? (Yes/No) If yes, when was the last visit? _____

Is the patient interested in a **Free Orthodontic Consult**? (Yes/No)

When was the patient's last cleaning? _____ Month(s) _____ Year(s)

Is the patient in pain? (Yes/No)



Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

Insurance:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Payment:

Understand that regardless of any insurance status, you are responsible for the balance due on your account, including any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

Payment is required in advance to reserve all treatment appointments. The amount required to reserve your appointment will be discussed with you at the time of scheduling. Any remaining balance is due at the time of service unless other arrangements have been made.

UNPAID BALANCES over 90 days old will be subject to monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

Missed appointments and cancellations:

We require at least 48 hours' notice to cancel or reschedule an appointment.

Appointments cancelled or rescheduled with less than 48 hours' notice, as well as missed appointments without notice, will be subject to a \$100 non-refundable cancellation/no-show fee.

Please help us maintain the highest quality of care by keeping your scheduled appointments or providing adequate notice when changes are necessary.

I have read, understand, and agree to the terms and conditions of this Financial Agreement.

Patient Name: _____

Patient/Parent Signature: _____

Date: _____



HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third-party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this Notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but you are not required to agree to these requested restrictions.

However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name:_____ Date:_____

Signature:_____



Assignment of Benefits Agreement

I hereby authorize Thrive Dental & Orthodontics to submit claims on my behalf to my dental insurance company and request that any payments of dental benefits be made directly to Thrive Dental & Orthodontics for services rendered.

I understand the following:

1. Authorization of Direct Payment I authorize and assign all dental benefits payable for services rendered by Thrive Dental & Orthodontics to be made directly to the practice. This includes, but is not limited to, benefits under my insurance plan, whether I am the insured party or a covered dependent.

2. Out-of-Network Insurance I understand that Thrive Dental & Orthodontics may be out-of-network with my insurance provider. While this Assignment of Benefits is submitted with my claim, some insurance plans may not honor this request and may send payment directly to me instead. If that occurs, I agree to forward the full insurance payment to Thrive Dental & Orthodontics immediately upon receipt.

3. Financial Responsibility I acknowledge that I am financially responsible for any charges not covered by my insurance plan, including deductibles, co-insurance, co-pays, and any services deemed non-covered or denied by my plan.

4. Insurance Coverage Limitations I understand that having insurance is not a guarantee of payment and that benefits are subject to the terms and conditions of my policy. Thrive Dental & Orthodontics will assist in filing claims but is not responsible for how insurance processes or pays those claims.

5. Release of Information I authorize the release of any dental and medical information necessary to process claims and communicate with my insurance company.

Acknowledgment

By signing below, I acknowledge and agree to the terms of this Assignment of Benefits form. I certify that the information provided is accurate and that I have read and understand my rights and responsibilities as stated above.

Signature of Patient or Legal Guardian: _____

Date: _____

Relationship to Patient (if applicable): _____