New Patient Form

PATIENT INFORMATION

Today's Date: _____
Name:_____
Date of Birth:_____ Age: _____
Male/Female
Race: _____ Ethnicity: _____
Primary Language: _____
SS#: _____
Home Address: _____
_____
_____
Home Phone: _____
Cell Phone: _____
Email: _____
Person Responsible for Account:_____
_____

Emergency Contact: _____
Relationship: _____
Phone: _____

How did you hear about our office?
_____

DENTAL INFORMATION

Primary Dental Insurance

Insurance Company: _____
Phone: _____
Group #: _____

Insured's Name: _____
Relation: _____
Insured's SS#: _____
Insured's Birthday: _____
Insured's Employer: _____

Secondary Dental Insurance (if any)

Insurance Company: _____
Phone: _____
Group #: _____

Insured's Name: _____
Relation: _____
Insured's SS#: _____
Insured's Birthday: _____
Insured's Employer: _____

Previous Dentist: _____

When was your last dental visit: _____

MEDICAL HISTORY

Height: _____ Weight: _____
Your current physical health is Good/Fair/Poor
Date of last medical exam: _____
Do you use or smoke Tobacco in any form? Yes No

Are you taking any prescription/ over-the-counter or herbal supplement drugs? Yes No
Please list each one: _____
Have you ever taken Phen-Fen? Yes No
(also known as Redux or Pondimin) if yes when? _____

FOR WOMEN:
Are you taking birth control pills? Yes No
Are you pregnant? Yes No Expected Deliver Date: _____
Are you nursing? Yes No
Is there a possibility of pregnancy? Yes No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your doctor for assistance regarding additional methods of birth control.

MEDICAL HISTORY Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Herpes/fever blisters
Y N Alcohol/Drug Use
Y N High Blood Pressure
Y N Anemia
Y N HIV+/Aids
Y N Arthritis
Y N Hospitalized for any reason
Y N Artificial Bones/Joints/valves
Y N Kidney Problems
Y N Asthma
Y N Liver Disease
Y N Blood Transfusion
Y N Low Blood Pressure
Y N Cancer/Chemotherapy
Y N Lupus
Y N Colitis
Y N Mitral valve prolapse
Y N Congenital Heart defect
Y N Pacemaker
Y N Diabetes

Y N Psychiatric Problems
Y N Difficulty Breathing
Y N Radiation Treatment
Y N Emphysema
Y N Rheumatic/Scarlet fever
Y N Epilepsy
Y N Seizures
Y N Fainting Spells
Y N Shingles
Y N Frequent Headaches
Y N Sickle Cell Disease
Y N Glaucoma
Y N Sinus Problems
Y N Hay Fever
Y N Stroke
Y N Heart Attack
Y N Thyroid Problems
Y N Heart Murmur
Y N Tuberculosis (TB)
Y N Heart Surgery
Y N Ulcers
Y N Hemophilia
Y N Venereal Disease
Y N Hepatitis

ALLERGIC REACTIONS:

Are you allergic to any of the following:
Y N Aspirin
Y N Erythromycin
Y N Penicillin
Y N Codeine
Y N Jewelry/Metals
Y N Tetracycline
Y N Sulfa
Y N Latex
Y N Dental Anesthetics

Please list any other drugs/materials you are allergic to:
_____
_____
_____

Please list any medical conditions you have ever had: _____
_____

DENTAL HISTORY

You current dental health is: Good/Fair/Poor?

Are you currently in pain? Y N

Have you had problems with previous dental work? Y **N**

Reason for today's visit: _____

Has your doctor told you that you require antibiotics before dental treatment? Y N

Do you experience pain/discomfort in your jaw (TMJ or TMD)? Y N

Do your gums ever bleed? Y N

The above information is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. Destiny Dental may disclose my healthcare information to my insurance company in order to obtain payment. I hereby assign directly to Destiny Dental all insurance benefits, if any, for rendered services. I understand that I am financially responsible for all charges whether or not paid for by my insurance and that payment is required before receiving services.

I have received a Notice of Privacy Practices from Destiny Dental. _____ (initial)

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

_____

We will not retaliate against you for filing a complaint.

Effective Date _____ Publication Date _____

DESTINY DENTAL
contact@destinydentalcare.com

OFFICE POLICY AND FINANCIAL TERMS

Understanding the specific requirements of your insurance plan can be difficult. The following information is designed to help answer any questions you may have regarding your insurance coverage and the payment policies of our office.

If You DO NOT Have Insurance, We ask that you pay for your office visit at the time of your appointment.
If You Have Private Insurance, Please give your insurance card and any necessary claim forms to front desk staff during your appointment. As a convenience to you, we will complete the forms and submit them directly to your insurance company. (If this is the selection you make below). You may be required to make a payment (co-payment, partial payment, deductible, etc) for your visit today. We will make every effort to have that information available to you by the time you complete your exam.

If You Belong To Health Maintenance Organizations (HMOS). If we are affiliated with your HMO, please show us your HMO membership card. If we are not affiliated with your HMO, you will be responsible for the cost of your appointment. We ask that you pay this fee at the time of your visit.

Fees We share your concern about the increasing costs of dental care. Because statements and billing fees have become so expensive and in an effort to keep your dental costs down, we ask that you pay your estimated co-payment for your procedure at the time the service is rendered. We will be happy to discuss fees with you, and an estimate of fees for any procedure(s) will be given when requested.

Insurance We remind you that the responsibility rests with the patient being treated or the parent/guardian. For office visits we expect payment at the time of that office visit by cash or credit card. We remind you that most insurance contacts involve deductibles and/or percentage allowances with the result that the entire bill is seldom covered in full. Should we receive any payment that exceeds your balance due, the excess will be promptly refunded to you. We know questions can arise on insurance matters and these should be discussed with our front desk staff. We will be happy to help you receive maximum benefits; however, the agreement of the insurance company to pay for dental care is a contract between you and the company. Feel free to address any questions regarding your bill to our office at (773) 783-9000 during regular business hours.

Cancellations: We require at least 24 hours notice to change your appointment; otherwise there will be a $50.00 charge. This policy does not apply to patients with All Kids insurance.

Payment: Payment is expected when services are rendered.

Late and Finance Charges: A $25.00 late payment (or no payment) charge may be applied to accounts that are late or no payment is made. A 1.5% finance charge will be added per month to all overdue accounts.

Delinquency: If your account falls into delinquency, you agree to pay any and all collection agency charges, attorney fees and court fees.

WE OFFER TO BILL YOUR INSURANCE COMPANY AS A COURTESY TO YOU. HOWEVER, YOUR CO-PAY MUST BE PAID AT THE TIME OF YOUR APPOINTMENT, WHEN DENTAL PROCEDURE IS COMPLETED. YOU HAVE THE FOLLOWING THREE (3) OPTIONS: (Please select one option by placing your initials on **ONE** of the three selections below, thank you).

☐ We will send out a Pre-Treatment Estimate to your Insurance Company for approval. When we receive the estimate from your insurance company, you will be responsible for amounts they do not cover at the time of your procedure(s).

☐ You pay an estimated co-pay at the time of your visit and we will bill your insurance company for the procedures performed. You may have a balance after the insurance benefits are received. If you have a balance due, we will bill you for the difference, that payment will be due upon receipt of our bill. If you have a credit due from us, we will send a check for the over payment immediately. Or, if you wish we may apply the credit towards any future services.

☐ You pay the entire balance and bill your insurance company yourself.

____/____/____ _____
Date Name (printed)

_____
Name (signature)

destinyDENTAL
Care for KIDS & Adults

INFORMED CONSENT FOR TREATMENT

This form is to obtain your consent for your child's dental treatment or oral surgery procedures. Please read this form very carefully and ask us about anything that you do not understand. Your child's dentist or the dental staff will be pleased to explain it. Thank you.

A. Below is a list of dental procedures that may be performed on your child. A treatment plan will be made for your child and presented to you after the initial examination. Prior to each appointment the specific treatment that will be performed on your child that day will be explained to you.

1. **Diagnostic Procedures:** Examination, radiographs (x-rays) of the teeth & jaws, consultation, photographs, dental casts.
2. **Teeth Cleaning:** Removal of soft and hard deposits on teeth, and teeth polishing with special toothpaste.
3. **Fluoride Treatment:** A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay.
4. **Dental Sealants:** Plastic sealants are applied to the grooves of the chewing surface of newly erupted permanent molar teeth to help resist tooth decay.
5. **Local Anesthesia Injection:** "Numbing medicine" carefully used to numb the teeth and surrounding areas prior to certain dental procedures such as tooth removal and dental fillings
6. **Dental Rubber Dam:** A sheet of latex rubber used to carefully isolate the teeth that need dental treatment.
7. **Dental Fillings/Crowns:** Depending on the size of tooth decay, and location of tooth in the mouth, the following may be done. Front teeth: white filling/crown. Back teeth or canine teeth: silver amalgam filling or stainless steel crown.
8. **Pulp (tooth nerve) Treatment:** A procedure to save baby teeth and certain permanent teeth that would otherwise be lost because of a deep cavity that has affected the tooth nerve. Saving a baby tooth that would normally be expected to remain in the mouth for nine months or more is recommended because it provides the child with a chewing surface. Also, baby teeth serve as natural space maintainers for the adult teeth growing underneath them.
9. **Extraction (Removal) of Teeth:** Teeth may be removed because of infection, injury, orthodontic reasons (teeth crowding), or if they are diseased and cannot be saved by any dental procedures.
10. **Space maintainer:** Recommended when baby teeth are lost prematurely. Helps maintain the natural space intended for a permanent tooth by preventing adjacent teeth from drifting together and forcing permanent teeth to erupt in a crowded condition.

B. The nature and purpose of the treatment and procedures have been explained to me in general terms by the dental staff of Destiny Dental. Alternate procedures or methods of treatment if any, have been explained to me. I have also had the advantages, disadvantages, risks, consequences and probable effectiveness of each explained to me, as well as the prognosis if no treatment is provided.

C. I am advised that though the results of the treatment are expected to be good, the possibility and nature of complications cannot be accurately anticipated for each individual. Therefore, there can be no guarantee as expressed or implied either of the result of the treatment or of the cure.

D. **Risks and Complications:** Although their occurrence is not frequent, some **risks and complications** are known to be associated with dental or oral surgery procedures. The **more common complications** associated with pediatric dental treatment include **nausea** following the administration of **topical fluoride** and children **biting** and **injuring** their **tongue or lip** following the administration of **local anesthesia. Less common complications** include the risks of numbness, infection, swelling, prolonged bleeding, discoloration of tissues, vomiting, allergic reactions, swallowing or aspiration of dental materials, an extracted tooth or gauze packing; injury to the tongue or lips, damage to and possible loss of existing teeth and or fillings, injury to nerves near the treatment site, and fracture of a tooth root which may require additional surgery for its removal. **For children with certain heart diseases, the risk of Infective Endocarditis (heart infection) following certain dental procedures exists.** Therefore, antibiotics will be prescribed before the treatment, to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment that may require hospitalization.

E. I hereby acknowledge that I have read and understand this consent form. I have been given an opportunity to ask any questions that I might have. All questions about the procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my child's dental treatment. I also understand that I am free to withdraw my consent to treatment at any time. This consent shall remain in effect until I choose to terminate it.

Do you have any objections? _____Yes _____No
If yes, please explain? _____

F. By signing this consent form, I authorize and direct the dentists at Destiny Dental assisted by the dental staff of his/her choice, to perform upon my child (or legal ward for whom I am empowered to consent) the dental treatment or oral surgery procedures explained herein.

Today's date: _____ Time: _____

Patient's Name:_____ Date of Birth:_____

Printed Name of person completing form _____Signature of person competing form_____

Your relationship to patient: _____Are you legally responsible for this child?_____ Yes_____No

destinyDENTAL
Care for KIDS & Adults

INFORMED CONSENT FOR TREATMENT OF CHILD
(OPTIONAL)

This form is to obtain your consent for your child's dental treatment or oral surgery procedures. Please read this form very carefully and ask us about anything that you do not understand. Your child's dentist or the dental staff will be pleased to explain it. Thank you.

A. Below is a list of dental procedures that may be performed on your child. A treatment plan will be made for your child and presented to you after the initial examination. Prior to each appointment the specific treatment that will be performed on your child that day will be explained to you.

1. **Diagnostic Procedures:** Examination, radiographs (x-rays) of the teeth & jaws, consultation, photographs, dental casts.
2. **Teeth Cleaning:** Removal of soft and hard deposits on teeth, and teeth polishing with special toothpaste.
3. **Fluoride Treatment:** A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay.
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7. **Dental Fillings/Crowns:** Depending on the size of tooth decay, and location of tooth in the mouth, the following may be done. Front teeth: white filling/crown. Back teeth or canine teeth: silver amalgam filling or stainless steel crown.
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9. **Extraction (Removal) of Teeth:** Teeth may be removed because of infection, injury, orthodontic reasons (teeth crowding), or if they are diseased and cannot be saved by any dental procedures.
10. **Space maintainer:** Recommended when baby teeth are lost prematurely. Helps maintain the natural space intended for a permanent tooth by preventing adjacent teeth from drifting together and forcing permanent teeth to erupt in a crowded condition.

B. The nature and purpose of the treatment and procedures have been explained to me in general terms by the dental staff of Destiny Dental. Alternate procedures or methods of treatment if any, have been explained to me. I have also had the advantages, disadvantages, risks, consequences and probable effectiveness of each explained to me, as well as the prognosis if no treatment is provided.

C. I am advised that though the results of the treatment are expected to be good, the possibility and nature of complications cannot be accurately anticipated for each individual. Therefore, there can be no guarantee as expressed or implied either of the result of the treatment or of the cure.

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Do you have any objections? _____Yes _____No
If yes, please explain? _____

F. By signing this consent form, I authorize and direct the dentists at Destiny Dental assisted by the dental staff of his/her choice, to perform upon my child (or legal ward for whom I am empowered to consent) the dental treatment or oral surgery procedures explained herein.

Today's date: _____ Time: _____

Patient's Name:_____ Date of Birth:_____

Printed Name of person completing form _____Signature of person competing form_____

Your relationship to patient: _____Are you legally responsible for this child?_____ Yes_____No