

Get Acquainted Questionnaire

In order for us to better serve you, please fill out the following information **COMPLETELY**

Name: _____
(first) (middle) (last) (preferred)

Address: _____
(number & street) (city) (state) (zip code)

Social Security #: _____ Date of Birth: _____

Home Telephone: _____ Business Telephone: _____

Email: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Whom may we thank for referring you? _____

Are you married? Yes ___ No ___ Spouse's name: _____

Emergency Contact

Name: _____ Phone Number: _____

Relationship to Patient: _____

For Patients with Dental Insurance

Primary Insurance

Insurance Carrier: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: _____

SS#(or ID#) _____ DOB: _____

(if different from above)

Secondary Insurance

Insurance Carrier: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: _____

SS#(or ID#) _____ DOB: _____

If patient is a student – Name of school: _____

I hereby authorize The Exchange Dental Group and its dentists to release to _____ or its representative, and information including the diagnosis and the
(Name of Insurance Company)
records of any treatment or examination rendered to me during the period of such Dental care. I also authorize and request your company pay directly to The Exchange Dental Group the amount due to me in my pending claim for dental treatment or services, by reason of such treatment or services rendered.

Signature of Insured: _____ Date: _____

MEDICAL HISTORY

Are you currently under the care of a physician? No ___ Yes ___ Please explain _____

Are you taking any prescription/over the counter drugs? No ___ Yes ___ Please list each one _____

For Women: Do you take any form of birth control? No ___ Yes ___ Which kind? _____

Are you pregnant? No ___ Yes ___ How many weeks? _____

Are you nursing? No ___ Yes ___

Do you have or have you ever had any of the following diseases or medical problems? **If NO, please circle NO**

- | | | |
|--------------------------|------------------------------|---------------------------|
| Y N Heart Attack | Y N Stroke | Y N Cancer |
| Y N Chemotherapy | Y N Heart Murmur | Y N Heart Defect |
| Y N Rheumatic Fever | Y N HIV | Y N AIDS |
| Y N Heart Surgery | Y N Pacemaker | Y N Heart Surgery |
| Y N Pacemaker | Y N Shingles | Y N Mitral Valve Prolapse |
| Y N Kidney Problems | Y N Artificial Bones, Joints | Y N Artificial Valves |
| Y N Sinus Problems | Y N High Blood Pressure | Y N Low Blood Pressure |
| Y N Fever Blisters | Y N Blood Transfusion | Y N Migraines |
| Y N Psychiatric Problems | Y N Epilepsy | Y N Seizures |
| Y N Fainting Spells | Y N Diabetes | Y N Tuberculosis(TB) |
| Y N Venereal Disease | Y N Hemophilia | Y N Abnormal Bleeding |
| Y N Ulcers | Y N Colitis | Y N Anemia |
| Y N Radiation Treatment | Y N Asthma | Y N Arthritis |
| Y N Difficulty Breathing | Y N Hospitalized | Y N Hepatitis |
| Y N Glaucoma | Y N Emphysema | Y N Crohn's Disease |

Please list any other serious medical condition(s) that you may have ever had: _____

Are you allergic to any of the following drugs? **If No, please circle NO**

- | | | |
|------------------|------------------------|-----------------|
| Y N Penicillin | Y N Tetracycline | Y N Latex |
| Y N Aspirin | Y N Codeine | Y N Ibuprofen |
| Y N Erythromycin | Y N Dental Anesthetics | Y N Sulfa Drugs |

Please list any other drugs that you are allergic to:

DENTAL HISTORY

Have you ever had a serious problem associated with any previous dental work? No ___ Yes ___

Have you ever experienced pain/discomfort in your jaw (TMJ/TMD)? No ___ Yes ___

Do you like your smile? No ___ Yes ___

Do your gums ever bleed? No ___ Yes ___

How many times a week do you floss? _____

How many times a day do you brush? _____

I affirm that the information that I have given today is correct to the best of my knowledge. I understand that The Exchange Dental Group safeguards my information in accordance with the HIPPA guidelines. I also understand that it's my responsibility to inform the office of any changes in my medical history.

I authorize, with informed consent The Exchange Dental Group to perform any necessary dental services to help maintain my oral health, including diagnosis and treatment.

Signature _____

Date _____

Financial Policy

The Exchange Dental Group strives to be punctual, therefore we ask that our patients keep their appointments and also arrive on time. If a patient must cancel an appointment, we require at least 24 hours notice, with the exception of Sunday appointments which must be cancelled by Friday 12pm the latest. **There will be a \$100 charge for EACH appointment missed or not cancelled 24 hours prior to the scheduled time, or by Friday 12pm respectively.**

The Exchange Dental Group will make every effort possible to assist our patients with their insurance, however please keep in mind that dental insurance is a contract between the insurance company and the patient, not the dental provider. It is up to the patient to fully understand his/her benefits to ensure the appropriate disbursement of benefits under the terms of each individual plan.

It is the patient's responsibility to notify The Exchange Dental Group should there be any change in the insurance plan. It is also the patient's responsibility to notify us of any dental procedures that have been done in **other** dental offices that may reduce the insurance benefits available for the year.

As a courtesy to our patients, The Exchange Dental Group provides a treatment plan of which includes an estimate of the recommended treatment, the expected coverage from the dental coverage as well as the patient's copayment respectively. **Benefits quoted to you are only an estimate provided by the insurance company and not a guarantee of payment or eligibility at the time the services are performed.** The Exchange Dental Group will submit claims and accept the assignment of benefits from the insurance company on behalf of the patient provided the patient pays their co-payment for each visit, due at the time of treatment, unless prior arrangements have been made, as we offer various financial programs to assist our patients with affordable monthly payments.

In the event that the claim is not paid by the insurance company within 30 days, the balance becomes the patient's responsibility and is due immediately. Any balances that remain unpaid after 90 days will be turned over to collections.

* Please note that a \$25 returned check fee will be added to the balance for all returned checks.

A misunderstanding can be an obstacle in establishing a successful relationship. If at any time you have a question regarding treatment, fee or service, please discuss it with us promptly and openly.

I, the undersigned, have read and understood the above and I consent to all the terms and conditions set forth in this agreement.

Signature _____ Date _____

Thank you for your cooperation and welcome to our practice!

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ✓ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- ✓ Obtain payment from third-party payers
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name of Patient: _____ Date: _____

Signature: _____

Other Individuals Allowed Access To My Records:

Spouse _____

Mother _____

Father _____

Son/Daughter _____

Significant Other _____

Other _____