Patient Information

First Name: ___________________________Last Name: _____________________________ M: __

Address: ____

City/State/Zip: ____

Home Phone: __________________________ Cell Phone: ___________________________________

Birth Date: ____________________   Age: ______   Soc. Sec: ______________________________

Email: ____ Employer: ___________________________

Whom may we thank for referring you?

____

Child Responsible Party

Name of Person Responsible: _____________________________________ DOB: _______________

Phone Number: _______________________ Address: ______________________________________

Soc. Sec: _______________________________Driver's License: _____________________________

Relationship to Patient: ____

Patients with PPO Dental Insurance→

Primary Insurance

Name of Insured: ______________________________________ Insured DOB: __________

Insured Soc. Sec: ______________________________ Insured Employer: ______________

Relationship to Insured: Self ◯ Spouse ◯ Child ◯ Other ◯

Name of Insurance Company: ____

ID Number: ____________________________

Group Number: _________________________

Ins. Company Phone Number: ____

Name: ____

Dental History

Check any that may apply:

- ☐ Pain in mouth
- ☐ Sensitivity (hot, cold, sweets, pressure)
- ☐ Discomfort when chewing
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, chipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you ever had the following?

- ☐ Braces
- ☐ Periodontal (gum) treatments
- ☐ CPAP machine
- ☐ Dentures

Are you interested in:

- ☐ Closing spaces
- ☐ Replacing old crowns that don't match other teeth
- ☐ Whitening
- ☐ Straightening your teeth
- ☐ Replacing silver fillings with tooth colored fillings
- ☐ Replace missing teeth
- ☐ Repair chipped teeth

Name of Previous Dentist:

____

City and State:

____

Phone Number:

____

What is the reason for your visit today? ____

When was your last dental visit?____

Medical History

Please check all that apply:

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes: Type 1, Type 2
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur/Mitral Valve Prolapse
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Pregnant (currently)
  - Weeks:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stent
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco User (currently)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: ______________________

Please List Any Medications You Take:

____
____
____
____
____
____
____

Are you taking medications for osteoporosis or Paget's disease (such as Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia)?

- ☐ Yes
- ☐ No

If Yes, Please list:

____
____

Do you have any allergies? Yes / No

- ☐ Penicillin
- ☐ Clindamycin
- ☐ Sulfa Drugs
- ☐ Codeine
- ☐ Latex
- ☐ Costume Jewelry
- ☐ Other: _______________

Family Doctor: ____ Phone Number:____________________

Patient Signature: ____ Date:_________________

Doctor Signature: ____ Date:_________________

General Treatment Consent

Patient Name: ____ DOB: ____________

I give consent for myself to receive dental treatment deemed necessary by the providers at Vivid Dentistry. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

Signature: ____

Date: ________________

I refuse or withdraw my consent for treatment

Signature: ______________________________________

Date: ______________________

Witness Signature: ________________________________

VIVID DENTISTRY
FINANCIAL POLICY

Assignment and Release
I the undersigned, have insurance with __________________________, and assign directly Vivid Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _______________ Signature: ____
Signature of patient/parent/legal guardian

Patient Agreement and Financial Policy
I hereby agree to be responsible for the costs of care provided by Vivid Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that there will be a $35 charge to all accounts in which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. ***For appointments scheduled for extensive procedures, I will be required to make a reservation fee of $100 prior to scheduling the appointment, which will be applied to my out-of-pocket expense for the appointment. This reservation fee is non-refundable. If I do not show up for my appointment or I do not give adequate notice if I am unable to keep my appointment, the reservation fee will be forfeited. For all appointments scheduled, a cancellation fee may apply if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment performed, payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a $15 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _______________ Signature: ____
Signature of patient/parent/legal guardian

Minor/Child Consent
I, being the parent or legal guardian of ______________________, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _______________ Signature: ____
Signature of patient/parent/legal guardian

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Vivid Dentistry. I hereby authorize, as indicated by my signature below, Vivid Dentistry to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

___________________________________ ___________________________________
Print Name Address

___________________________________ ____________
Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _______________________________

☐ You may contact me on my mobile telephone number ______________________________

☐ You may contact me on my work telephone number _______________________________

☐ You may send me an unencrypted email/text message at: ___________________________

☐ Other ____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ____ Date Added / Removed:___________

2. ____ Date Added / Removed: ___________

3. ____ Date Added / Removed: ___________

4. ____ Date Added / Removed: __________

* * *

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) ____

Staff Person Initials ___________