

WELCOME

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____

First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Birthdate _____ Age _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)

Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

Phone Numbers

Phone (_____) _____ Work (_____) _____ Ext _____ Alt.Phone (_____) _____

Spouse's Work (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____

Relationship _____

Phone (_____) _____

Work Phone (_____) _____

Dental History

Reason for today's visit _____

Yes No Chew on one side of mouth

Yes No Mouth breathing

Yes No

Cigarette, pipe, or cigar smoking

Yes No Mouth pain, brushing

Yes No

Clicking or popping jaw

Yes No Orthodontic treatment

Yes No

Dry mouth

Yes No Pain around ear

Yes No

Fingernail biting

Yes No Periodontal treatment

Yes No

Food collection between the teeth

Yes No Sensitivity to cold

Yes No

Foreign objects

Yes No Sensitivity to heat

Yes No

Grinding teeth

Yes No Sensitivity to sweets

Yes No

Gums swollen or tender

Yes No Sensitivity when biting

Yes No

Jaw pain or tiredness

Yes No Sores or growths in your mouth

Yes No

Lip or cheek biting

Yes No

Yes No

Loose teeth or broken fillings

Yes No

Yes No

Burns

Yes No

Yes No

Wounds

Yes No

Yes No

Bruises

Yes No

Yes No

Scars

Yes No

Yes No

Bruising

Yes No

Yes No

Wounds

Yes No

Yes No

Scars

Yes No

Yes No

Bruising

Yes No

Yes No

Wounds

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Yes No

Yes No

Scars

Yes No

Yes No

Bruising

Yes No

Yes No

Wounds

Yes No

Yes No

Scars

Yes No

Yes No

Bruising

Yes No

Yes <input type="checkbox

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date _____ Are you nursing? Yes No

Taking birth control pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Dr. Aimee Vakula-Rollins

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today either received or reviewed a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient Signature

Patient Name (please print)

I am also signing for my minor children: _____

(please print names)

Date: _____

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature

Patient Name (please print)

I am also signing for my minor children: _____

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver)

(please print names)

I also give my permission for information regarding _____ treatment _____ appointments, _____ insurance benefits, _____ financial arrangements to be discussed with the above individuals.

Date: _____

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

Office Personnel (signature)

Office Personnel (print name)

Date: _____

Dr. Aimee Vakula-Rollins

PATIENT COMMUNICATION PREFERENCES

To Our Valued Patients:

We are updating our records to determine the best way to communicate with you regarding treatment and appointments in our practice, as well as information regarding your dental health.

Please let us know your preferred method for receiving messages from us:

Cell phone – number: _____

Home phone – number: _____

Work phone – number: _____

Email: _____

In the event you cannot be reached directly by phone, is there someone we may leave a message with? (e.g. spouse, partner) Name: _____

Relationship: _____ Phone number: _____

May we send text messages to you regarding your appointments? Yes _____ No _____

Please send text messages to (number) _____

May we send e-mail messages to you regarding your appointments? Yes _____ No _____

In the future we may send electronic billing statements to you when applicable.

Would you like to receive electronic statements from our practice? Yes _____ No _____

Would you like to receive electronic newsletters from our practice? Yes _____ No _____

Name

Signature

Date

Aimee D. Vakula-Rollins, D.D.S., P.L.L.C.
FINANCIAL POLICY

Insured Patients:

Financial arrangements must be made prior to treatment.

- Your insurance is a contract between you, the insured, and the insurance company.
- Although your insurance may assist you with partial payment of your treatment, the *estimated* portion, which is not covered, is due when services are rendered.
- As a courtesy to our patients, we will bill your primary insurance company. If your insurance has not paid within 60 days, you will be billed for the entire balance and payment will be expected at this time. We will, however, continue to work with you or your insurance company to expedite your reimbursement.
- It is your responsibility to keep our office informed of any changes pertaining to your employment or insurance coverage.

The services rendered by this office will be coded according to the American Dental Association's guidelines and submitted electronically.

Payments may be made by any of the following methods, please indicate your method of below.

CASH _____

CREDIT CARD _____

CHECK _____

CARECREDIT _____

- I understand that my insurance may pay only a portion of the claim(s) submitted, and I am ultimately financially responsible, and I agree to pay for all expenses incurred for the services rendered by this office.
- I request that all insurance benefits be paid directly to Dr. Vakula-Rollins. If payment by the insurance company is made to the insured, I agree to endorse, or have the insured endorse the check, and/or make payment immediately to Dr. Vakula-Rollins. I further authorize the release of information to my insurance company necessary to determine liability for payment and to obtain reimbursement of any claim.
- A billing charge of 2.00% (per statement) will be applied to any unpaid portion of your balance.
- In the event that this account is assigned to an attorney or agency for collection and/or suit, I agree to pay the attorney's or agency's fees, court cost, and interest from the date of treatment.
- A charge of \$25 will be applied to broken appointments (i.e. No shows or cancelled in less than 24 hours prior to the time of the appointment)
- A charge of \$25 will be applied to all returned checks.

I understand and agree to all the above conditions of this Financial Policy.

Patient/Parent or Guardian (if a minor)

Date

Soc. Sec. #

(PLEASE TURN OVER AND COMPLETE OTHER SIDE)

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(print full name of patient)
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient _____ Signature (if a minor, Parent or Guardian) _____ Relationship to Patient _____ Date _____