Justin C. Flood, DMD

REGISTRATION AND HEALTH HISTORY

Date: _______________

First Name: _________________ M.I. ____ Last Name: __________________ ☐ male ☐ female Date of Birth: ______________ (Enter as MMDDYYYY) Age: _____

Address: ______________________________________ City: ____________________ State: __________________ Zip: __________

Home Phone: ______________ Work Phone: _______________ Cell Phone: ______________ Social Security#: ______________ (Do NOT include dashes or spaces)

Email Address: ____ Emergency Contact: ____________________________________

Marital Status: ☐ Married ☐ Single Student: ☐ Full-time ☐ Part-time ☐ N/A Occupation: ________________________________

What would you prefer to be called? ___________________ Who may we thank for this referral? ___________________________

Family Physician: ___________________________________ Phone#: _________________

Dental Insurance Carrier: _____________________________ ID#: _________________________ Group #: ______________________

☐ Check this box ***ONLY*** if the Insured person *(the person receiving dental service)* is the same as applicant above. If not, enter Insured info below.

Name of Insured: ___________________________________ Insured's SS#: ______________ (Do NOT include dashes or spaces) Insured's Date of Birth: ____________ (Enter as MMDDYYYY)

Relationship to Insured: ___________________________

Employer of Insured: _________________________________ ☐ Full-time ☐ Part-time ☐ Retired Phone#: _________________

Employer Address: ________________________________ City: _________________ State: _________________ Zip: _________

Who is financially responsible for this account? ____ Phone#: _________________

Please select Y = Yes or N = No if you have any of the following conditions:

☐Y ☐N - Rheumatic Fever	☐Y ☐N - Thyroid Disease	☐Y ☐N - Seizure Disorder
☐Y ☐N - Heart Disease	☐Y ☐N - Anemia	☐Y ☐N - Kidney Disease
☐Y ☐N - Heart Murmur (or MVP)	☐Y ☐N - Asthma	☐Y ☐N - Venereal Disease
☐Y ☐N - High Blood Pressure	☐Y ☐N - Diabetes	☐Y ☐N - Bleeding Problems
☐Y ☐N - Tuberculosis	☐Y ☐N - Are you nursing	☐Y ☐N - Cancer
☐Y ☐N - Use Oral Contraceptives	☐Y ☐N - Might you be pregnant	☐Y ☐N - Aids/HIV
☐Y ☐N - Artificial Joint / Heart Valve	☐Y ☐N - Hepatitis Type: ☐ A ☐ B ☐ C	☐Y ☐N - Eating Disorders
☐Y ☐N - History of Endocarditis	☐Y ☐N - Radiation Therapy: Head / Neck	☐Y ☐N - History of HPV

Other conditions not listed: ____

Are you allergic to latex, soy, egg, milk, dairy or nuts products? ____

List any antibiotics, anesthetics or other drugs you are allergic to: ____

List all prescription/OTC medications, vitamins and/or supplements you are presently taking: __________________________

____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? ___________________

Do you have, or have you ever had clicking, popping or pain in your tempromandibular joints (TMJ)? ________________________

Have you been hospitalized in the past five years? ☐ Yes ☐ No If yes, why? _______________________________________

Do you take aspirin on a daily basis? ☐ Yes ☐ No If yes, why? ____

Are you under a physician's care presently? ☐ Yes ☐ No If yes, why? ____

Have you ever been a drug or substance abuser? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No How much? ___________________

Is there anything you would like to discuss with the Doctor in private? ____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to Justin C. Flood, DMD unless otherwise indicated.

Signature: ____ **Date:** _______________________

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms as well as releasing Dr. Flood to utilize any dental photographs for lecturing and educational purposes.

Justin C. Flood, DMD

DENTAL HEALTH

Reason for visit: ______________________________ Approximate date of last dental visit: ____________

What is your primary concern that you would like us to address first? ______________________________

When would you like us to start treatment? ______________________________

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ☐ Yes ☐ No

If so, explain: ______________________________

What, if anything, has happened in previous experiences at the dentist that was reason not to return? ____________

____

Do you ever feel (or have you ever been told) that you don't have fresh breath? ______________________________

How often do you brush your teeth? ____ time(s) a ________ How often do you floss? ____ time(s) a ________

What type of brush do you use? ☐ Manual ☐ Powered

Do you avoid brushing any part of your mouth because of pain? ☐ Yes ☐ No If yes, what part? ____________

Which foods cause you twinges of pain: ☐ Hot ☐ Cold ☐ Sweet ☐ Sour ☐ None

Do your gums feel tender or swollen? ☐ Yes ☐ No

Do you chew on only one side of your mouth? ☐ Yes ☐ No If yes, explain: ______________________________

Do you clench or grind your jaws while sleeping or during the day? ☐ Yes ☐ No Do your jaws ever feel tired? ☐ Yes ☐ No

Please add anything you feel is important:

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________________ Please ***print*** name of Patient

______________________________ Please ***sign*** for Patient/Guardian of Patient

______________________________ Legal Representative/Guardian

______________________________ Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ______________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

____
Signature of Privacy Officer

HIPAA made EASY™
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Justin C. Flood, DMD

FINANCIAL MENU

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals,we need your assistance and your understanding of our payment policy. For your convenience we offer a wide range of financial options in order to pay for your dental treatment:

A) Split Payment

Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/bridges/veneers.

B) Pay as You Go

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

C) Prepayment in Full

For any treatment over $2000, a prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

D) CareCredit

CareCredit offers No Interest financing for up to 24 months and low monthly payment options. There are no up front costs, no prepayment penalties and no fees as long as it is paid in full by the end of the term. This allows you to get the necessary work done now and pay later.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best dental care possible, you may choose from any of the following:
Cash, Visa, MasterCard, Personal Checks or CareCredit (see above).

Interest of 1.5% per month will be charged on any unpaid balance after 60 days. This allows sufficient time for your insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 30 days. Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all feed for services rendered. We will gladly assist you in any way we can.

I understand that if I become delinquent on my account, my account will be turned over to a collection agency and I will subsequently be reported to the credit bureaus. In case of total default I agree to pay all costs for collection including but not limited to interest, court costs, sheriff fees, attorney fees and collection costs that may be incurred to collect on this account.

Please be aware that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered.

After your dental insurance has paid for dental services rendered at Justin C. Flood, DMD, you may have an outstanding balance. This balance may include any deductibles, copayments, denials, and non-covered services. We do our best to estimate what you will owe. For balance owed, we will require a credit card authorization, or you may need to pay your entire balance up-front.

Credit Card: (check one): ☐ Visa ☐ MasterCard ☐ CareCredit

Card#:__________________________ Expiration Date:________ CVV #:________

(Do NOT include dashes or spaces) *(Enter as MMYY)*

Card Holder Signature:____

Billing Address:______________________________ State:_____ Zip:________

I certify that I have read, fully understand, and accept the above financial policy.

Signature: ____ **Date:**____________________

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APPOINTMENT AGREEMENT

At our practice, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 business hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 business hours, you will be subject to a $50 late cancellation charge.

By signing below, I agree to fulfill my obligation as a patient at the practice of Justin C. Flood, DMD and agree to the "broken appointment" fee should I not give proper notification.

_______________________________________ ____________________

Signature of Patient or Responsible Party **Date**

Completion Instructions

Thank you for taking the time to complete our New Patient Welcome Packet. Please print the entire document and bring it to your first appointment visit.

If you have any questions, please contact our office at (610) 584-6700.

Thank you,
Justin C. Flood, DMD