Patient Information

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

Email _____ Social Security # _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Person to Contact in Case of Emergency _____ Phone _____

Patient Medical History

Physician _____ Office Phone _____

Are you experiencing/have you experienced any of the following? (Mark all that apply):

☐ High Blood Pressure	☐ Heart Disease	☐ Chest Pains
☐ Heart Attack	☐ Cardiac Pacemaker	☐ Stroke
☐ Rheumatic Fever	☐ Heart Murmur	☐ Hay Fever/Allergies
☐ Fainting/Seizures	☐ Angina	☐ Tuberculosis
☐ Asthma	☐ Anemia	☐ Radiation Therapy
☐ Low Blood Pressure	☐ Emphysema	☐ Glaucoma
☐ Epilepsy/Convulsions	☐ Cancer	☐ Liver Disease
☐ Leukemia	☐ Arthritis	☐ Heart Trouble
☐ Diabetes	☐ Joint Replacement or Implant	☐ Respiratory Problems
☐ Kidney Diseases	☐ Hepatitis/Jaundice	☐ Mitral Valve Prolapse
☐ AIDS or HIV Infection	☐ Sexually Transmitted Disease	☐ Other _____
☐ Thyroid Problem	☐ Stomach Troubles/Ulcers	

	Yes	No
1. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
2. Do you use tobacco?	☐	☐
3. Do you use controlled substances?	☐	☐
4. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

5. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____		

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____

_____

Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____

_____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

Do you like your smile? _____ Any Dental Concerns? _____

Patient Dental Insurance

Primary Insurance:

Name of Insured _____ Birthdate _____ SS#/ID# _____

Insurance Company _____ Group# _____ Name of Employer _____

Secondary Insurance:

Name of Insured _____ Birthdate _____ SS#/ID# _____

Insurance Company _____ Group# _____ Name of Employer _____

Financial Policy

It is the policy of this office to help keep your health care costs as low as possible. In order to so this, we try to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current dental insurance card to the office.
- Please notify us of any changes in insurance, address, phone number, etc. as soon as you arrive.
- You will be responsible for paying your Copayment at the time of service as well as any outstanding balance on your account. If you do not have insurance, please be prepared to pay for your visit in full unless other arrangements have been made.

Copayments: We are required by all our insurance contracts to collect all copayments at the time of service. Copayments can be made in cash, check, or credit card (Visa, MasterCard, American Express, or Discover).

Monthly Statements: If you have a balance on your account of more than $2.00, we will send you a monthly statement. You will be notified of balances less $2.00 when you have a scheduled appointment.

Payments: Unless other arrangements are approved by Pinnacle Family Dentistry, the balance on your statement is due and payable upon receipt of the statement and is past due if not paid within 30 days of statement date. When necessary, payment plans can be arranged based on the balance on your account.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect the debt. If we have to refer your account to an outside collection agency, you agree to pay all the collection costs that are incurred.

Uninsured Patients: Pinnacle Family Dentistry's policy is to assist those patients without insurance coverage in meeting their financial obligation to pay for services rendered in a fair and consistent manner. Please notify us before treatment is rendered if you will need help in meeting your financial obligations.

Insurance: It is the responsibility of the cardholder to know what their eligibility and coverage is with their current insurance carrier. If this is not known, the cardholder should verify coverage limitations prior to the appointment date. You agree to pay any portion not covered by your insurance, including your deductible, copayments and any services your plan determines to be not covered by your plan.

Multiple Insurance: If you have multiple insurance plans, it is your responsibility to see that they coordinate correctly. Please make sure our office always has the correct primary and secondary insurance order. Any Coordination of Benefits (COB) issues, i.e. the process of determining the respective responsibilities of two or more health plans that have some financial responsibility for a dental claim, are the patient's responsibility. If the patient does not resolve COB issues before the insurance filing limit, the balance will be due and payable by the patient.

Insurance Release: This is to certify that I have been informed prior to receiving treatment that my insurance may not be liable for services rendered if any of the following conditions apply:

- I may have used all my benefits for the year at another office
- Services may not be covered under my plan
- I may have a pre-existing condition or other diagnosis that may not be covered by my insurance
- Pinnacle Family Dentistry may not participate in my dental plan

I have read this Financial Policy as outlined above and on the front of this page and understand that I am ultimately responsible for the charges incurred, and I request services be performed.

I understand that if I fail to make payment when due and my account becomes delinquent, it can be turned over to a collection agency for collection.

Printed Patient Name:_____ Patient D.O.B:_____

Patient/Responsible Party Signature: _____

Date of Signature: _____ Staff Initials: _____

The entire team in our office works hard to make sure our patients receive the highest standard of care. Occasionally, there are times when it is necessary for Dr. Mulzer to be out of the office. Our hygienists have completed additional training in the management of emergencies in the dental office and have obtained approval from the Kentucky Dental Board to see patients when Dr. Mulzer is not in the office. Such visits will be for simple hygiene procedures only, and an exam must have been done by Dr. Mulzer within the past seven months prior to the visit.

The Kentucky State Dental Board requires permission to be given by each patient seen when Dr. Mulzer is not present in the office. Please check one of the two items below and sign this form at the bottom.

Thank You

O I agree to be seen by the hygienist when Dr. Mulzer is not present in the office

O I do not agree to be seen by the hygienist when Dr. Mulzer is not present

_____ _____

Patient/Guardian Signature Date

Acknowledgement of receipt of notice of privacy policy

You may refuse to sign this acknowledgement

I, _____, have been offered a copy of this office's Notice of Privacy Policy.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt or our Notice of Privacy Policy, but acknowledgement could not be obtained because:

- Individual refused to sign this form
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____