New Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us – we will be happy to help.

Whom may we thank for referring you to our practice? _____

ABOUT YOU

Name: _____ I prefer to be called _____ ( )Male ( )Female

( )Single ( )Married ( ) Divorced ( )Child ( )Other Birth Date: _____Soc. Sec. #: _____

Home Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____ext. ___

Email address: _____ Employer: _____

PERSON RESPONSIBLE FOR ACCOUNT

( )Same as above /Name: _____Birth Date: _____ Relation: _____

Billing Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Soc. Sec. #: _____

CONTACT IN CASE OF EMERGENCY

Name: _____ Phone : _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Company:_____ Phone: _____ Group #: _____

Insured's Name: _____Insured's DOB: _____Insured's ID/SS #: _____

Ins. Co. Address:_____ Employer:_____

Secondary Insurance

Insurance Company:_____ Phone: _____ Group #: _____

Insured's Name: _____Insured's DOB: _____Insured's ID/SS #: _____

Ins. Co. Address:_____ Employer:_____

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: _____

Do you have or have ever had any of the following? Please check those that apply:

( ) Allergies/Hay Fever	( ) Epilepsy/Seizures	( ) High Blood Pressure	( ) Rheumatism
( ) Anemia	( ) Excessive Thirst	( ) HIV*/AIDS	( ) Sickle Cell Disease
( ) Angina	( ) Fainting/Dizziness	( ) Kidney Problems	( ) Sinus Problems
( ) Arthritis	( ) Frequent Cough	( ) Liver Problems	( ) Stroke
( ) Artificial Joints*	( ) Glaucoma	( ) Mental Disorder	( ) Surgical Shunt*
( ) Artificial Heart Valves*	( ) Heart Disorder-congenital*	( ) Mitral Valve Prolapse	( ) Thyroid Problems
( ) Asthma	( ) Heart Infection*	( ) Multiple Piercings	( ) Tuberculosis
( ) Breathing Problems	( ) Heart Murmur*	( ) Multiple Tattoos	( ) Ulcers
( ) Cancer	( ) Heart Pace Maker	( ) Osteoporosis	( ) Venereal Disease
( ) Chemical Dependency	( ) Heart Surgery*	( ) Radiation	( ) Yellow Jaundice
( ) Chemotherapy	( ) Hepatitis A , B, C	( ) Respiratory Problems	( ) Other _____
( ) Diabetes	( ) Herpes	( ) Rheumatic Fever	

* This condition may require antibiotic premedication for certain dental procedures

YES NO

( ) ( ) Do you have any health problems that were not listed above or need further clarification?
If yes, explain: _____

( ) ( ) Are you now under the care of a physician?
If yes, explain: _____

( ) ( ) Have you been admitted to a hospital or needed emergency care during the past 2 years?
If yes, explain: _____

( ) ( ) Are you taking any medications or herbal remedies?
If yes, explain: _____
_____

Are you allergic to any medications or substance? If yes, please check box below:

( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Iodine ( ) Metal ( ) Latex ( ) Other _____

WOMEN (please check) ( ) Pregnant ( ) Trying to get pregnant ( ) Nursing ( ) Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X_____ Date _____

Signature of patient, parent or guardian

DENTAL HEALTH QUESTIONAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health they deserve and want. This begins with a careful diagnosis and treatment plan. We will perform a comprehensive oral examination of your teeth, gums, joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial, we may take additional records such as photographs or casts of your teeth to further evaluate areas of concern.

Please help us better understand your dental health needs and goals by answering the following questions. Check the best answers:

1. I have a **( ) low ( ) moderate ( ) high** fear of going to the dentist.

2. My mouth and teeth are **( ) very ( ) moderately ( ) not** comfortable.

3. I am **( ) very satisfied ( ) satisfied ( ) not satisfied** with the appearance of my teeth.

4. I think the present state of my dental health is **( ) excellent ( ) good ( ) fair ( ) poor.**

5. My main dental concerns are: _____
   _____

6. I am interested in whitening or improving my smile with cosmetic dentistry. ( ) Yes ( ) No

7. Please check the following conditions, if they apply to you:

( ) swollen, bleeding gums	( ) bad breath	( ) bad taste in mouth
( ) painful gums or teeth	( ) sensitivity to hot, cold, sweets	( ) clenching or grinding
( ) loose teeth	( ) increased spacing between teeth	( ) other _____

8. Please check the statement below that represents the level of dental health you wish to achieve.

   ( ) **Health Level 1 – Emergency Care**
   I am interested in emergency dental care for the relief of pain and/or cosmetic embarrassment. I am NOT interested in thinking about the future of my teeth at this time.

   ( ) **Health Level 2 – Maintenance Care**
   I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

   ( ) **Health Level 3 – Comprehensive Care**
   I am interested in comprehensive care to achieve and maintain a higher level of dental health. I am concerned about treating the causes of dental diseases, not simply the affects. I want all dental treatment provided to be the best available for maximum protection and longevity, to achieve long-term stable dental health.

   ( ) **Health Level 4 – Comprehensive and Cosmetic Care**
   I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health. I am concerned about treating the causes of dental diseases, not simply the affects. I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, to achieve long-term stable, yet esthetic, dental health.

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us, please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must, we ask that you provide us 48 hour notice so that we use our time to accommodate other patients. If not, a $50 charge will be incurred. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, **payment in full is due the day of treatment**. Should a patient have dental insurance with assignment to our office, the balance is due upon receiving a statement from our office. Insurance payments that are made directly to the patient, should be endorsed to the office and mailed in with the remainder of the balance upon receipt.

Payment Options

1. For your convenience we accept Cash, Check, Visa, Mastercard, American Express and Discover.
2. We also offer short and long-term interest free financing options through Care Credit.

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is responsible for the difference. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you if treatment is necessary.

Finance Charges and Fees

1. Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).
2. Returned checks are subject to a $25 accounting fee.
3. If your account is turned over to collections, you will be responsible for paying any legal fees that the practice accrues.

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination by Dr. Cyril Mansperger. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information
I authorize Dr. Mansperger to release any of my information regarding my dental/medical history, diagnosis, or treatment to third payers and/or other health care professionals.

Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to Dr. Mansperger.

I understand and will comply with the office Appointment Policy.
I understand and will comply with the office Financial Policy.
I understand and agree to the General Consent to Treatment.
I authorize the Release of Information.

X _____ Date _____
Signature of patient, parent, or guardian

PATIENT HIPAA AWARENESS

With my permission, Dr. Cyril Mansperger may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Cyril Mansperger Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Dr. Cyril Mansperger reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Cyril Mansperger may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Cyril Mansperger may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Dr. Cyril Mansperger may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Cyril Mansperger restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Cyril Mansperger to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Name of Patient or Legal Guardian Date