Devonshire Dental Associates
Registration

Patient Information

Last Name	First		M.I.
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Birth Date	Age	☐ Male ☐ Female	Preferred Name
☐ Married	☐ Single	☐ Divorced	☐ Widowed
Social Security No.	E-Mail Address		

Dental Insurance

Primary Insurance		Secondary Insurance	
Insurance Company		Insurance Company	
Group No.		Group No.	
Employer Name		Employer Name	
Insured Name	Date of Birth	Insured Name	Date of Birth
Insured's I.D. #		Insured's I.D. #	
Insured's Soc. Sec. #		Insured's Soc. Sec.	
Relationship to Patient		Relationship to Patient	

Account Information

Person responsible for account			Your Spouse		
Relationship to Patient	Soc. Sec. #		Name		
Address			Employers Name		
City	State	Zip	Phone		
Home Phone	Work Phone		Patient Here? ☐ Yes ☐ No		
Credit Card on File		Exp.	Address		
Employer	Occupation		City	State	Zip

Consent for Treatment

a. I authorize the doctor or his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.
b. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.
c. I agree to the use of anesthetics and other medication as necessary, and further understand that these may carry certain risks. I understand that I may ask the doctor for a complete listing of possible complications.

Patient's Signature_____ Date _____ Witness_____

Parent/ Responsible Party's Signature _____ Relationship to Patient _____

Devonshire Dental Associates
Dental History

Reason for today's visit	Date of last dental visit
Former Dentist	Date of last dental X-Rays
Former Dentist's Address	Dentist's phone

Check (√) if you have had any of the following:

☐ Bad Breath	☐ Grinding teeth	☐ Periodontal treatment
☐ Bleeding or sensitive gums	☐ Growth in your mouth	☐ Root Canal Treatment
☐ Broken filling	☐ Head or neck injury	☐ Sensitivity to cold
☐ Broken tooth	☐ Jaw Pain	☐ Sensitivity to hot
☐ Chewing difficulty	☐ Loose teeth	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Oral Surgery	☐ Sensitivity when biting
☐ Food between teeth	☐ Orthodontic Treatment	☐ Sores in your mouth
Do you smoke? ☐ Yes ☐ No	Do you chew tobacco? ☐ Yes ☐ No	Clench your teeth? ☐ Yes ☐ No

How often do you brush?	How often do you floss?
Are you typically nervous about dental treatment? ☐ Yes ☐ No	If yes, what is your concern?

Medical History

Physician's Name	Date of last visit
Have you had any serious illnesses or operations? ☐ Yes ☐ No	If so, what?

(Women) Are you pregnant? ☐ Yes ☐ No | Nursing? ☐ Yes ☐ No | Taking birth control pills? ☐ Yes ☐ No

☐ Anemia	☐ Cortisone Use	☐ Hepatitis	☐ Respiratory Disease
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Coughing Blood	☐ HIV positive or Aids	☐ Scarlet Fever
☐ Artificial Joint	☐ Diabetes	☐ Kidney Disease	☐ Shortness of breath
☐ Asthma	☐ Epilepsy	☐ Latex sensitivity	☐ Stroke
☐ Back Pain	☐ Fainting	☐ Liver Disease	☐ Swelling of feet/ankles
☐ Blood Disorder	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Cancer	☐ Headaches	☐ Neurological disorders	☐ Tonsilitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Pacemaker	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Psychiatric Care	☐ Ulcer
☐ Circulatory Problem	☐ Hemophilia	☐ Radiation Treatment	☐ Venereal Disease

Have you had any blood transfusions? ☐ Yes ☐ No	If so, what for and when
Medications currently taking. Please list.	Allergies. Please list.

Consent

I understand that the above information is necessary to provide me with proper dental care. I have answered all the questions to the best of my knowledge. Should further information be required, you have my permission to ask a respective health care provider or agency, who may release such information to you. You have my permission to disclose health information to insurance companies for the purpose of obtaining payment and determining insurance benefits. I will notify the doctor of any changes in my heath status or medications.

Patient/ Guardian Signature	Date

Devonshire Dental Associates
Payment Policies

We are pleased to answer any questions you may have about your bill. While dental benefits vary among the many employer benefit plans, we can often help you understand your coverage. Our payment policies are as follows:

General Policy

1. Payment is due in full on the day you receive dental services. We cannot bill for these services. We accept cash, checks, Visa, and Master Card..

2. If you are having crowns, veneers, onlays, mouth guards or other work that must be sent to a dental laboratory, we require 50% deposit on the day impressions are taken. (These labs require payment on the day they receive your impressions). At your final appointment to receive your crowns, onlays, etc., we will ask you for final payment in full.

3. For all procedures exceeding $1000, we require that a credit card be placed on file, even if your dental insurance is to be billed. Your card will not be billed until 30 days after your insurance company settles your claim. Within that period you are welcome to pay by check if you like.

4. Late balances are charged a service charge of 1.5% (18 APR). We do not offer payment plans or third party financing.

Dental Insurance

1. With the exception of some preventative procedures such as cleanings and x-rays, your dental insurance company will not fully cover the cost of treatment. You are responsible for the portion they do not cover, payable on the day your receive treatment. Typical reimbursements by insurance companies range from 40% to 65%.

2. Some insurance companies, including Delta Dental and Blue Cross/Blue Shield will not reimburse you for white composite fillings. Instead, they reimburse you for lees expensive silver/mercury fillings. If you have one of these plans, you may be responsible for up to 60% of the cost of these fillings.

3. Most dental insurance plans have a maximum yearly benefit of $1000, while some plans may be more. We cannot submit work done in one calendar year for the next calendar year.

4. Most dental plans have a deductible that you must pay each year, typically $50. Usually the deductible does not apply to preventative work.

5. Since we administer hundreds of employer benefit plans, we cannot know the details of every plan. It is the patient's responsibility to know the details of their coverage. To submit an insurance claim, you must present a dental benefit card with your group number on it.

I have read and agree to the payment policies of Devonshire Dental Associates. If my credit card is on file, I give my permission to charge my card for balances not covered by my Dental Insurance.

_____ _____

Name Date

Devonshire Dental Associates
Notice of Privacy Practices

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. Our complete Privacy Practices are available for you to read. A copy is kept in our Patient Waiting Room. You may choose to read that entire document before signing this consent form. We will disclose your health information when we are required to do so by law.

Patient Rights

You have the right to look at or get copies of your health information, with limited exceptions. If you require copies of x-rays, there is a charge of $35 for this service. X-ray information will be provided in digital format on a floppy disk. We will forward your health information to other health agencies with your written request. We ask that you sign an additional consent form to have your records released. We may disclose appointment reminders to you via postcard or e-mail.

Uses and Disclosure of Health Information

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Healthcare Operations: We may use and disclose your health information for treatment, payment or healthcare operations. These include staff meetings, quality assessments, evaluation of practitioner and provider performance, and conducting training programs.

Persons Involved In Care: In the case that you are incapacitated or there are emergency circumstances, we will disclose health information using our professional judgment to persons involved in your care. We will also use our judgment of your best interests in allowing such persons to pick up medical supplies, x-rays, or other health information.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health of safety of others.

Authorization

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices at any time. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Devonshire Dental Associates. We may decline treatment if you revoke this consent. You are entitled to request a copy of this Consent.

Signature Patient/ Guardian _____ Date _____