Salmon Brook Dental

creating beautiful smiles

Patient Information:

First Name:_____ M. Initial:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Ph:_____ Cell Ph:_____ Work Ph:_____

Birth Date:____/_____/_____ Soc. Sec:_____ Email:_____

Responsible Person (if other than patient):

First Name:_____ M. Initial:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Ph:_____ Cell Ph:_____ Work Ph:_____

Birth Date:____/_____/_____ Soc. Sec:_____ Email:_____

Insurance Information (Primary):

Name of Insured: _____

Ins. SS#:_____

Ins DOB:_____

Employer:_____

Ins. Carrier:_____

Group #:_____

Member I.D.:_____

Insurance Information (Secondary):

Name of Insured:_____

Ins SS#:_____

Ins DOB:_____

Employer:_____

Ins. Carrier:_____

Group #:_____

Member I.D.:_____

Dental Medical History

Patient Name:_____ Age:_____ Date of Birth:_____/_____/_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Allergies: **None** ☐

☐ Acetaminophen ☐ Aspirin ☐ Cephalosporins ☐ Chlorhexidine (CHX) ☐ Codeine
☐ Erythromycin ☐ Fluoride ☐ Gluten ☐ Ibuprofen ☐ Latex/Rubber/Vinyl
☐ Local Anesthetic ☐ Metals: (Nickel, Gold, Silver _____) ☐ Nuts / Fruit
☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other_____

If you answer yes to the following questions, please explain on the blank provided.	YES	NO
Have you ever been hospitalized or had a major operation?_____	☐	☐
Have you ever had a serious head or neck injury?_____	☐	☐
Are you taking any medications, pills, or drugs?_____	☐	☐
If yes please provide a MED List: _____	☐	☐
Do you take, or have you taken Phen-Fen or Redux?_____	☐	☐
Have you ever taken Fosamax, Bonia, Actonel, or any other medication with bisphosphonates?	☐	☐
If yes please provide which one(s):_____	☐	☐
Are you on a special diet?_____	☐	☐
Do you use tobacco or tobacco products? _____	☐	☐
Do you use controlled substances? _____	☐	☐

Women: (Check All That Apply) None: ☐
☐ Pregnant ☐ Trying to Get Pregnant ☐ Taking Oral Contraceptives ☐ Nursing

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	YES	NO
Have you ever had a serious injury that is not listed below?_____	☐	☐
If yes, please provide that name: _____		

Are there any additional comments you would like Salmon Brook Dental know in regards to your medical history? _____

To the best of my knowledge, the questions in this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patients') health. It is my relationship to inform the dental office of any changes in my medical status.

_____ Date: _____/_____/_____
Signature of Patient or Legal Guardian

Please review the next page and provide answers to the best of your knowledge. Thank you!

Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
AID/HIV Positive			Cortisone Medicine			Hemophilia			Recent Weight Loss		
Alzheimer's Disease			Diabetes			Hepatitis A			Renal Dialysis		
Anaphylaxis			Drug Addiction			Hepatitis B or C			Rheumatic Fever		
Anemia			Easily Winded			Herpes			Rheumatism		
Angina			Emphysema			High Blood Pressure			Scarlet Fever		
Arthritis / Gout			Epilepsy or Seizures			High Cholesterol			Shingles		
Artificial Heart Valve			Excessive Bleeding			Hives or Rash			Sickle Cell Disease		
Artificial Joint			Excessive Thirst			Hypoglycemia			Sinus Trouble		
Asthma			Fainting Spells/Dizziness			Irregular Heartbeat			Spina Bifida		
Blood Disease			Frequent Cough			Kidney Problems			Stomach/Intestinal Disease		
Blood Transfusion			Frequent Diarrhea			Leukemia			Stroke		
Breathing Problem			Frequent Headaches			Liver Disease			Swelling of Limbs		
Bruise Easily			Gential Herpes			Low Blood Pressure			Thyroid Disease		
Cancer			Glaucoma			Lung Disease			Tonsillitis		
Chemotherapy			Hay Fever			Mitral Valve Prolapse			Tuberculosis		
Chest Pains			Heart Attack/Failure			Osteoporosis			Tumors or Growths		
Cold Sores/Fever Blisters			Heart Murmur			Pain in Jaw Joints			Ulcers		
Congenital Heart Disorder			Heart Pacemaker			Parathyroid Disease			Venereal Disease		
Convulsions			Heart Trouble/Disease			Psychiatric Care			Yellow Jaundice		
						Radiation Treatments					

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Salmon Brook Dental Associates, LLC
Financial Policies

We at Salmon Brook Dental Associates are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive care today. We feel a clear understanding of our policy is important to our professional relationship.

Insurance:

As a courtesy to our patients, we gladly process your insurance claims. We participate in different insurance plans. But please inquire if we accept yours to avoid billing problems later. We **ESTIMATE** your deductible for the year and your portion due that is not covered insurance. The total portion that is not covered by insurance is **DUE AT THE TIME OF YOUR APPOINTMENT**. Parents MUST send co-pays due with minors at the time of their appointment. **Please Initial:**_____

Missed Appointments / Cancellations:

Twenty four (24) hour notice is required for cancellation of appointments. We reserve the right to charge a fee for broken appointments or ones that are not canceled beforehand within a reasonable time frame. If repeated "No Shows" occur, you will be charged $50.00 for care.
Please Initial:_____

Payment Options:

1. Cash
2. Personal Checks
3. Visa, MasterCard, Discover and American Express
4. CARECREDIT: offers patients a line of credit to cover you or your family's dental care needs. In most important situations this is an interest free program for up to a year. This program is most helpful for allowing you to begin your treatment immediately and spread the cost over a period of time. Inquire with office staff to attain further information regarding the different programs they offer.
5. Lending Point: is an online lender offering personal loans from $2,000 to $36,500.

I understand and agree that, regardless of my insurance (if applicable), I am ultimately responsible for the balance on my account for all charges and services rendered. I have read all the information on this sheet. **Please Initial:**_____

If you have any questions, please feel free to inquire before signing below.

I have read and understand the above policies.

Print Name:_____ Date:_____

Patient Signature:_____

Parent/Guardian Signature (if patient is under the age of 18):_____

HIPAA

(Acknowledge of Receipt)

The **HIPPA PRIVACY RULE** establishes national standards to protect patients' health records and other personal health information and applies to health plans, health care clearinghouses and those health care providers that conduct health care transactions electronically.

I acknowledge that I have received a copy of Salmon Brook Dental Notice Privacy Practices.

Patient Name: _____ Date: _____

Signature: _____

Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Salmon Brook Dental Associates, Dr. Kenneth Endres, DDS and Dr. Gunveen Chawla, DDS to release my medical and/or billing information to the following individual(s):

1. _____ Relation: _____ Phone #: _____
2. _____ Relation: _____ Phone #: _____
3. _____ Relation: _____ Phone #: _____

Patient Information I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Signature:_____Date:_____

Salmon Brook Dental Associates, LLC
Dental Record History

Oftentimes it is necessary to obtain your complete dental history in order to devise a treatment place that will properly address all your immediate and long term dental needs. This consent gives our office permission to obtain those records on your (or your dependents) behalf.

Previous Dentist Name:_____ Phone #:_____

Email Address:_____ Fax #:_____

Office Address:_____

City:_____ State:_____ Zip:_____

Date of Last Known X-Ray:_____

I authorize Salmon Brook Dental Associates to request and receive any and all previous dental charting as they pertain to the above named patients dental health and treatment.

_____ D.O.B _____/_____/_____
Print Name of Patient or Legal Guardian

_____ Date:_____
Signature of Patient or Legal Guardian

All patients over the age of 18 ***MUST*** sign their own forms. Patients under that age of 18 years ***CAN NOT*** sign for themselves. Only a parent or a legal guardian may sign for a patient under the age of 18.

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