



904-783-1633
NormandyDentistry.com

Patient Information

Today's Date: _____

Patient Name: _____ Preferred Name: _____
Last First MI

Male Female Married Single Child Other _____
Responsible Party for child: _____

May we contact you in regards to your account activity using the personal information below? Yes No

SS # Patient: _____ SS # Responsible Party: _____

Phone (Home): _____ (Work): _____ Emergency contact: _____ Cell: _____

Birth Date: _____ E-Mail Address: _____

Home Address: _____
Street City/State Zip Code

Employer Name: _____ Position: _____ How long there?: _____

Please list other members of your immediate family who are patients in our office that you would like to have linked with your account _____

Referral Information

Can we thank someone for referring you?

Family Member _____
Coworker _____
Friend _____
Doctor _____

Or did you find us on your own?

- Our Website
- Yellow Pages
- Lumineer or 6 Month Braces Referral
- Insurance Company
- Location
- Mail
- Other _____

What is the reason for your visit today? _____

Date of Last Dental Visit: _____

Do you prefer Nitrous Oxide (laughing gas) during dental procedures? Yes No

Are you interested in sedation dentistry? Yes No

Why did you leave your previous dentist? _____

If you could change your smile and/or oral health, what would you do? Check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Straighter teeth | <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Fresher Breath |
| <input type="checkbox"/> Whiter Teeth | <input type="checkbox"/> Lower cavity risk | <input type="checkbox"/> Less Pain in Jaw |
| <input type="checkbox"/> Eat and Chew Better | <input type="checkbox"/> Get rid of ugly dark fillings | <input type="checkbox"/> Taste food better |
| <input type="checkbox"/> Stop snoring | <input type="checkbox"/> Better fitting denture | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Grinding/Clenching/Clicking | | |

Do you prefer to see a particular doctor in our practice? _____

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

HEALTH QUESTIONNAIRE

Today's Date: ____ / ____ / ____ Patient Name: _____ DOB: ____ / ____ / ____

Name of person completing form (if different from patient) and relation to patient: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality of care. All information you provide will be kept confidential.

If yes, please explain...

- Are you under a physician's care now? Y N
- Have you ever been hospitalized or had a major operation? Y N
- Have you ever had a serious head or neck injury? Y N
- Are you taking any medications, pills, or drugs? Y N
- Do you take, or have you taken Phen-Fen or Redux? Y N
- Have you ever taken Fosamax, Boniva, Actonel or any other medication containing Bisphosphonates? Y N
- Are you on a special diet? Y N
- Do you currently use tobacco? Y N
- Have you ever used tobacco? Y N
- Do you use controlled substances? Y N
- Have you ever used controlled substances?** Y N

| |
|--|
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| |
| |
| |
| |

Women: Are you
 Pregnant/Trying to get pregnant? Nursing?
 Taking Oral Contraceptives?

Are you allergic to any of the following? Check all that apply.

- Aspirin
- Penicillin
- Codeine
- Local Anesthetics
- Acrylic
- Metal
- Latex
- Sulfa Drugs

Other: _____

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

| | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|-------------------------|--|
| AIDS/HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Acid Reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No | Daytime Sleepiness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hive or Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gastric/Intest. Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cord Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

Have you ever had any serious illness not listed above? Yes No If Yes, please explain _____

I also understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

____ / ____ / ____
Date

Print Name of person completing forms

Signature of person completing forms

INSURANCE INFORMATION

Primary Dental Insurance *if available*

Dental Insurance Company: _____ Policy Holder's Employer: _____
Policy Holder's Name: _____ Policy Holder's SS#: _____
Last First MI
Policy Holder's Date of Birth: _____ Insurance Co. Phone #: _____

Secondary Dental Insurance *if available*

Dental Insurance Company: _____ Policy Holder's Employer: _____
Policy Holder's Name: _____ Policy Holder's SS#: _____
Last First MI
Policy Holder's Date of Birth: _____ Insurance Co. Phone #: _____

Medical Insurance

Medical Insurance Company: _____ Policy Holder's Employer: _____
Policy Holder's Name: _____ Member ID#: _____
Last First MI
Policy Holder's Date of Birth: _____ Insurance Co. Phone #: _____

OPTION TO AUTHORIZE RELEASE OF INFORMATION TO FAMILY MEMBERS

Today's Date: ____ / ____ / ____ Patient Name: _____ DOB: ____ / ____ / ____

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

I authorize Normandy Dentistry to release my dental and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Please list all authorized person(s) who will bring your child/children to their dental appointment. We require a six month medical update to be completed at your child's appointment, thus making the person bringing your child to the appointment responsible for any medical changes, current medications and dental concerns.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____

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 the federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing

____ / ____ / ____
Date

Print Name of person completing forms

Signature of person completing forms



CONSENT FOR SERVICES AND FINANCIAL POLICY

Thank you for choosing Normandy Dentistry as your premier Dental Care Provider. We are fully committed to making your experience and dental care here as comfortable and extraordinary as possible. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. As a condition of your treatment by this office, financial arrangements must be made in advance. Please understand that payment of your bill is considered a part of your treatment. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All patients must complete our Information and Insurance form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, CARE CREDIT

DENTAL INSURANCE:

Your coverage depends solely on what your employer purchases. Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your **ESTIMATED** co-payment by the day services are rendered. We will gladly file your insurance claim. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. If a balance is left on the account after 60 days, a statement of accounts will be sent and payment for any balance over 60 days will be due and payable by you and summed with interest charges. Any accounts with a remaining balance over 90 days old may be turned over to an attorney or collections agency.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will require a signed consent form and payment at time of scheduling.

MISSED APPOINTMENTS

We respectfully ask that you give us a minimum of 48 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION & RELEASE

I authorize this office to perform diagnostic procedures (exams, x-rays, study models, and photographs) appropriate to make thorough diagnosis of the patient's dental needs. I also authorize this office to perform any and all treatment that may be indicated. I authorize the practice to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to Normandy Dentistry (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance over 60 days past due. In the event it should become necessary to place this account in the hands of an attorney or collection agency, you will be responsible to pay all collection fees (up to 50% of my account balance), plus attorney fees. I understand there is a \$30 fee for each returned check. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I understand Normandy Dentistry may need to verify my information and/or evaluate my credit history for purposes of setting up financing or insurance benefits for myself or my dependents. For quality assurance, I agree to have any photos, and/or video/audio recordings taken of me to be used for educational and training purposes.

Privacy: I have been informed of, and given the right to review and secure a copy of this office's *Notice of Privacy Practices*, which contains a complete description of the uses and disclosures of my protected health information, and my rights under HIPPA (the Health Insurance Portability and Accountability Act of 1996).

By signing below, I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____