RIGHT CARE DENTAL

**PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU**

PATIENT LAST NAME: _____ FIRST: _____ INITIAL: _____

How do you wish to be addressed? _____ DOB _____

(❑Single ❑Married ❑Divorced) (❑Male ❑Female) Full time Student? ❑ Yes ❑ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? ❑ Yes ❑ No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

How important is your oral health to you? How much do you like your smile? _____

***In a scale 1-10***, ( 1-4 Not Important - 5-7 Somehow Important - 8-10 Very Important )

What would you change about you smile? _____

## RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

## AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, Irevoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

Signature _____ Date _____

RIGHT CARE DENTAL

**PLEASE COMPLETE ALL INFORMATION – THANK YOU!**

**PATIENT LAST NAME:** _____ **PATIENT FIRST NAME:** _____

## DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

**Please check if you have/had:**

| | | | | | |
|---|---|---|---|---|---|
| Bad breath | ☐ | Gums swollen, tender, or bleeding | ☐ | Have you ever had an allergic reactions | ☐ |
| Blisters on lips or mouth | ☐ | Head, neck, or jaw pain or aches | ☐ | to Novocaine, local or general anesthetics? | |
| Burning sensation on tongue | ☐ | Lip or cheek biting | ☐ | *If Yes, please explain:* | |
| Chew on one side of mouth | ☐ | Loose teeth or broken fillings | ☐ | _____ | |
| Cigarette, pipe, or cigar smoking | ☐ | Mouth breathing | ☐ | | |
| Smokeless tobacco | ☐ | Orthodontic treatment | ☐ | Have you had trouble from previous | ☐ |
| Dry mouth | ☐ | Nitrous Oxide | ☐ | dental care? | |
| Food collection between teeth | ☐ | Periodontal treatment | ☐ | *If Yes, please explain what happened:* | |
| Clench teeth | ☐ | Sensitivity to pressure or irritants | ☐ | _____ | |
| Grind teeth | ☐ | (cold, heat, sweets) | | _____ | |
| Growths or sore spots in mouth | ☐ | How often do you floss? _____ | | | |
| | | How often do you brush? _____ | | | |

## MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Physician's address: _____

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: _____

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: _____

Pregnant? Yes ☐ Due Date? _____ Nursing? Yes ☐ Birth Control Pills? Yes ☐

**Please check if you have/had:**

| | | | | | |
|---|---|---|---|---|---|
| Allergies, hay fever, sinusitis | ☐ | Heart Problems | ☐ | | |
| Anemia | ☐ | Hepatitis? | ☐ | Thyroid Problems | ☐ |
| Arthritis, Rheumatism | ☐ | Type: _____ | | Tonsillitis | ☐ |
| Artificial Heart Valves | ☐ | Herpes | ☐ | Tuberculosis | ☐ |
| Artificial Joints | ☐ | High Blood Pressure | ☐ | Tumor or Growth on Head/Neck | ☐ |
| Asthma | ☐ | Any Immune Deficiency (incl. HIV/AIDS) | ☐ | Ulcer | ☐ |
| Asthma: Required Hospitalization | ☐ | Jaundice | ☐ | Venereal Disease | ☐ |
| Asthma: Used Steroids | ☐ | Kidney Disease | ☐ | Weight Loss, Unexplained | ☐ |
| Bleeding abnormally with operation/surgery | ☐ | Low Blood Pressure | ☐ | Do you wear contact lenses? | ☐ |
| Blood Disease, Clotting Disorders | ☐ | Mitral Valve Prolapsed | ☐ | Do you consume alcoholic beverages? | ☐ |
| Cancer | ☐ | Osteopenia | ☐ | Are you currently under the care of a | ☐ |
| Chemical Dependency | ☐ | Osteoporosis | ☐ | Physician? | |
| Chemotherapy | ☐ | Pacemaker | ☐ | Are you allergic/sensitive to Latex? | ☐ |
| Circulatory Problems | ☐ | Radiation Treatments | ☐ | Allergic to penicillin, Aspirin or Other Drugs? | ☐ |
| Cortisone Treatments | ☐ | Respiratory Disease | ☐ | *If Yes, please specify:* | |
| Cough, persistent or bloody | ☐ | Rheumatic Fever | ☐ | _____ | |
| Diabetes | ☐ | Scarlet Fever | ☐ | _____ | |
| Emphysema | ☐ | Shortness of Breath | ☐ | Are you currently taking any Medications? | ☐ |
| Epilepsy | ☐ | Sinus Trouble | ☐ | *If Yes, please list:* | |
| Fainting | ☐ | Sickle Cell Anemia | ☐ | _____ | |
| Glaucoma | ☐ | Skin Rash | ☐ | _____ | |
| Headaches | ☐ | Stroke | ☐ | _____ | |
| Heart Murmur | ☐ | Swelling of Feet/Ankles | ☐ | | |

## AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____

RIGHT CARE DENTAL

**PATIENT NAME:** _____ **DATE:** _____

***Right Care Dental***, is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- ***Right Care Dental* PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

## ADULT PATIENTS

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

## MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

## UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

## INSURANCE

***Right Care Dental*** provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by ***Right Care Dental*** staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to ***Right Care Dental***. However, if you are paid by the insurance company instead of ***Right Care Dental***, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

## MEDICARE/ MEDICAID/ WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the ***Right Care Dental*** office on the date of service.

## DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

## MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

***Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.***

**Responsible Party Signature** _____ **Date** _____

# PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH IMFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

# *CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

NI acknowledge that I have been provided with ***Right Care Dental,*** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

**Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de* ***Right Care Dental.,*** *y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

**Patient Name:** *(please print)* _____
**Nombre Del Paciente:** *(nombre en letra de molde por favor*

**Patient Signature** *(or legal representative; proof may be requested)* _____
**Firma Del Paciente:** *(o representante legal; prueba puede ser requerida)*

**Date:** *(dd/mm/yy)* _____
**Fecha:** *(dd/mm/aa)*

## EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM
## *CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

**Purpose:** This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. ***Right Care Dental.,*** **(RCD)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **RCD** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **RCD** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **RCD** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. ***Right Care Dental,*** **(RCD)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **RCD** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **RCD** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **RCD** y yo y consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

**Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente**

**My Consented Email Address is:** _____
***Mi Correo Electrónico Consentido es:**

**My Consented for Text Messaging to:** _____
***Mi Mensaje de Textos consentido a:**

**X** _____
**Patient Signature * Firma del Paciente**

RIGHT CARE DENTAL

# Dental Warranty

## "Right Care Dental" Dental Warranty

Our practice is proud of the great general dentistry care that we provide for you and your family. Our goal is not to just correct any dental or medical problems you may have, but to show you how to prevent disease in the future to save you time and money. The long-term success of the care we provide for you depends upon your continuing home care along with regular professional exams, cleanings, and fluoride treatments. The products recommended for you and the frequency of those professional re-care visits depend on your individual condition. Re-care visits may be every 3,4, or even 6 months apart depending on your oral health. With that in mind, we offer the following limited dental warranties:

### Dental Sealants

Sealants are plastic coating placed on the chewing surfaces of the teeth to prevent decay in the pits and grooves of the teeth. These are the most common areas to get cavities. Floss and use of fluoride will help prevent decay between the teeth. We will repair or replace sealant for at a period of 6 months after placement. If decay is present on the chewing surface, a filling will be done with a prorated credit for the sealant. The only exception to this is if the patient has had orthodontic care recommended but not done, then the warranty is void.

### Composite (Tooth Colored) Fillings

If a composite restoration is the recommended treatment of choice, we will replace or repair it in the event of a failure for a period of 3 months. If the tooth breaks and requires a crown, we will credit the prorated cost of the filling toward the crown. The only exception to this is if the patient has evidence of bruxism or clenching and does not wear a grinding guard or a sleep appliance, then the warranty is void.

### Root Canals

Root canal treatment is about 95% successful and requires a crown after, but they do occasionally fail. If you lose your tooth within 1year due to failure of the root canal, we will prorate a credit of the root canal's cost on any implant, bridge, or removable partial's denture cost.

### Crowns, Bridges, Porcelain Veneers and Inlays/Onlays

We will warranty these comprehensive procedures for a full 1 year. We will replace or repair them at no charge during this 12 months period if they break, or decay with normal use. The only exception to this is if the patient has evidence of bruxism or clenching and does not wear a grinding guard or a sleep appliance, then the warrantee is void.

## Dentures and Partial dentures

We will warranty dentures and partials for a period of 1 year if a tooth chips or breaks, or a flange breaks under normal use. This warranty does not cover accidents such as dropping your denture.

## Bite Guards for Grinding and Clenching

We warranty these appliances for 6 months against regular wear breakage. This warranty does not include dropping them. Patients must ALWAYS bring their oral appliance to their appointments to see if it is working.

## Invisalign, Braces, and Orthodontic Care

Retention! Retention! Retention! We recommend retainers be worn every night as long as you wish to have a beautiful, straight smile. That is why at the end of straightening your smile, we recommend the Retainer. Your smile is used to make a new retainer to that perfect smile.

## Dental Implants

Implants in our office have a 98% success rate. Implants do not have real allergies but 2% of the time can be rejected by certain patients and need to be removed. If a new implant and associate services: bone grafts, abutments, and crowns when repeated. If success is reached within 1 year, patient will have full responsibility of payment, if not, then you would be given a prorated credit to be utilized in other treatment options, such as conventional bridges, partial, or complete dentures. Implants are wonderful services to help our patients smile and feel confident.

*Note*: As you can see, we are confident of the durability of our treatment as prescribed for you. The primary key to your long-term success is spending a few minutes a day on your home care. This includes, brushing, flossing, fluoride, any prescribed products and care for your sleep appliances, retainers, or night guards. Proper daily care for any retainer, denture, partial, bite guard, sleep appliance, with sonic cleaners will help them last for years more. The second key to success is regular professional examinations, cleaning, x-rays, and fluoride treatments (3,4, and 6 months intervals depending on your oral condition). FAILURE TO HAVE THESE REGULAR VISITS AT OUT OFFICE VOIDS ALL WARRANTIES. Help us to help you maintain your teeth for a lifetime. If you come back for regular checkups and cleanings, your dental work and smile will last a lot longer!

Patient Signature: _____ Date: _____