FERMELIA
DENTAL

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (C): _____ (H): _____ (W): _____

Email: _____

SSN: _____ Employer: _____

Is the Patient the Responsible Party for Payment? □ Yes □ No If no, please fill out the information below.

Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (C): _____ (H): _____ (W): _____

Email: _____

SSN: _____ Employer: _____

_____ _____

Signature of Responsible Party Print Name Date

Reason for your Visit:

□ Exam/Cleaning □ Emergency □ Consultation □ Invisalign □ Other

If other, please explain: _____

Do you require antibiotic premedication prior to dental treatment? □ Yes □ No

Are you currently experiencing any dental pain? □ Yes □ No

If so, where and for how long? _____

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Please check the corresponding box if you are currently experiencing any of these problems:

- □ Red, Swollen or Bleeding Gums
- □ Sensitive Teeth or Gums
- □ Lost/Broken Fillings or Teeth
- □ Loose/Shifting Teeth
- □ Food Caught between Teeth
- □ Swelling/Lumps in Mouth
- □ Blisters or Sores in/around the Mouth
- □ Burning Tongue/Lips
- □ Stained Teeth
- □ Bad Breath

My teeth are sensitive to:

□ Hot □ Cold □ Sweets □ Biting/Chewing

Approximate date of last dental exam/x-rays: _____

How many times a day do you brush? _____

How many times a day do you floss? _____

Do you use an electric or manual toothbrush? _____

On a scale of 1 – 10, (10 being very healthy) how would you rate your general health? _____

Please mark all that apply to you:

- □ Locking Jaw
- □ Headaches/Migraines
- □ Difficult Swallowing
- □ Facial Pain
- □ Postural Problems
- □ Bell's Palsy
- □ Limited Jaw Opening
- □ Ringing in the Ears
- □ Clenching/Grinding
- □ Neck/Shoulder Pain
- □ Tingling Fingertips
- □ Trigeminal Neuralgia
- □ Jaw Joint Pain, Clicking or Popping
- □ Ear Congestion
- □ Difficulty Chewing
- □ Dizziness
- □ Nervousness/Insomnia

_____ _____

Signature of Patient, Parent, or Guardian Print Name Date

Relationship to Patient: _____

Please bring your dental insurance card & driver's license so we can make a copy for our records.

Patient Name: _____ Date: _____

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.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other?	☐	If yes
Do you use controlled substances?	Yes No	If yes

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

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

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

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

Signature of Patient, Parent or Guardian:

X Date:_____

FERMELIA DENTAL

HANDLE ME WITH CARE

Name: _____ Date: _____

We want you to be comfortable during your visit, so please put a checkmark next to the statement that describes how you feel about going to the dentist and your overall care. Check as many as you like.

- ☐ I gag easily.
- ☐ I feel out of control while lying in the dental chair.
- ☐ I have a problem with being tipped back in the dental chair.
- ☐ I am very anxious about injections.
- ☐ I hate the noise of dental instruments.
- ☐ I have not been seen by a dentist for a long time and I am worried about what you will tell me about my dental hygiene.
- ☐ I am embarrassed about the way my teeth look.
- ☐ I have had a bad experience and I have a lot of fear which has kept me from getting the dental care I need.
- ☐ I am very apprehensive about the possibility of experiencing pain.
- ☐ I have difficulty listening and remembering when I am in the dental chair.
- ☐ I want to be able to ask as many questions as necessary so that I understand why and what treatment is being recommended for me.
- ☐ I would like to see pictures and videos that will help me understand my dental problems and possible solutions.
- ☐ There are other concerns I would like to talk about: _____

_____

_____

Revised 4/6/18

HWC

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FERMELIA DENTAL

COMMUNICATION CONSENT FORM

Patient Name: _____

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our patients review and sign this Communication Consent Form.

Fermelia Dental will not release confidential and/or other Protected Health Information (PHI) in any written or recorded manner unless authorized by you to do so. Additionally, information will not be left with an unauthorized person who may answer the telephone or call in on your behalf.

I, _____, authorize Fermelia Dental to contact me and/or my named authorized person(s) to convey **Protected Health Information (PHI)** by the following methods and assume responsibility to notify Fermelia Dental when this information changes:

Email on record: ☐
Cell Phone on record: ☐
Home Phone on record: ☐
Home Address on record: ☐
Any of the Above: ☐
Other: _____

Fermelia Dental may need to contact you to discuss payment for services rendered.

I, _____, authorize Fermelia Dental to contact me and/or my named authorized person(s) to convey **billing information** by the following methods and the home address on record. I assume responsibility to notify Fermelia Dental when this information changes:

Email on record: ☐
Cell Phone on record: ☐
Home Phone on record: ☐
Any of the Above: ☐
Other: _____

Fermelia Dental uses text, email and phone reminders to confirm appointments.

I, _____, authorize Fermelia Dental to contact me and/or my named authorized person(s) to convey **appointment information** by the following methods and assume responsibility to notify Fermelia Dental when this information changes:

Email on record: ☐
Cell Phone on record: ☐
Home Phone on record: ☐
Any of the Above: ☐
Other: _____

FERMELIA DENTAL

Patient Name: _____

Who may we contact in case of an emergency?

Name: _____ Relationship: _____

Phone Number: _____

Please tell us who is authorized to receive protected information about your care:

Emergency Contact Listed above: ☐ Yes ☐ No

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

FERMELIA DENTAL OFFICE POLICY

Patient Name: _____

It is the goal of this office to provide you with the finest quality dental care possible. We believe that a clear definition of our financial and insurance policies will allow the patient, doctor and staff to concentrate on the most important issue—regaining and maintaining your dental health.

Payment for Services:

We require payment in full for all services rendered at the time of visit, unless other arrangements have been made in writing with our business manager. If an account is not paid within 90 days of the date of service and no financial arrangements have been agreed upon, you will be responsible for legal fees, collection agency fees, interest charge and any other expenses occurred in collecting your account.

Missed Appointments:

If you need to reschedule or cancel your appointment, we require 2 business days' advance notice to ensure we are able to best meet the needs of our patients that want in sooner. If you provide less than 2 business days' advance notice, you will be charged a $50.00 per hour missed appointment fee.

Dental Insurance:

As a courtesy to you, we will file your dental insurance claims for you. By signing this office policy, you are assigning all insurance benefits to us. Any deductibles and estimated co-payments must be paid on the day of service. If you prefer to submit your own dental claims, payment in full will be required on the day of service and you shall be provided with a copy of the statement.

Insurance Payments Only an Estimate:

Please understand that we are only able to estimate your insurance company's payment based on the information your insurance company provides us. Your dental insurance policy is a contract between you, your employer (if it is a group dental plan) and the insurance company. The dentist is not a party to the dental insurance contract. We do not guarantee that your insurance company will reimburse for services at the usual and customary fees nor does your insurance company guarantee the accuracy of benefits quoted to us by phone, fax, or online.

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FERMELIA
DENTAL

Balance Due:

Not all dental services are covered benefits in all dental (or medical) insurance contracts. The filing of insurance claims is a courtesy that we extend to our patients; however, all charges are your responsibility from the day services are rendered regardless of insurance coverage. Any balance due after an insurance payment is received is your financial responsibility and a bill will be sent to you within 30 days after receiving insurance payment. Any payment received in excess of your balance will be credited to your account. We will refund of any credit balance upon your request using the original method of payment, with the exception of cash payments which will be refunded via check. If you prefer you may also use this credit toward any future services with us instead.

Refund Policy:

There is a significant amount of time, professional resources and costs associated with providing a patient with a customized treatment plan. Additionally there are hard costs that are incurred for aligners, crowns, bridges, prosthetics, devices and oral appliances which are custom designed and manufactured for each patient and may be integral to the overall treatment provided. Because of this, Fermelia Dental does not issue refunds on products or services. We realize that circumstances may arise from time to time that require special consideration, therefore Fermelia Dental reserves the right to review any case on an individual basis and at our sole discretion.

By my signature below I acknowledge I have read and consent to the above policies, conditions of treatment and payment:

_____ _____

Signature of Guarantor of Payment/Responsible Party Date

Patient Name: _____ Relationship to Patient: _____

Revised 5/1/18

NP Consent Forms

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FERMELIA
DENTAL

CONSENT FOR SERVICES

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Fermelia Dental to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third-party payers (i.e. insurance companies) or other financial institutions (i.e. credit card companies, financing companies);
- The day-to-day healthcare operations of Fermelia Dental.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Fermelia Dental reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Fermelia Dental is not required to agree to these requested restrictions. However, if Fermelia Dental does agree, then Fermelia Dental is bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize Fermelia Dental to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

_____ _____

Signature of Patient, Parent, or Guardian Date

Printed Patient Name: _____ Relationship to Patient:_____

Revised 4/6/18

Np consents

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