REIGN DENTAL

Confidential Information Questionnaire

Please type or print below

Patient's Name Last First Middle Initial Date of Birth Gender M ☐ F ☐ Social Security # Marital Status M ☐ S ☐ D ☐ W ☐

Patient's Address Street Apt # City State Zip Home Phone

Patient's Employer Occupation Cell Phone

Work Address Street City State Zip Work Phone **E-Mail Address**

Spouse or Guardian Name Spouse/Guardian Employer Occupation Spouse/Guardian SSN#

Work Address City State Zip Work Phone Cell #

Emergency person we can contact (other than your family home) Work Phone Home Phone
Name Relationship

Names of other family members that are patients here **Who can we thank for referring you to our office?**

INSURANCE AND FINANCIAL INFORMATION

Insurance Company Name Insurance Address City State Zip Phone

Subscriber's Name Subscriber's Date of Birth Subscriber's SSN #

Group/Program Number Subscriber's Employer Employer's Address

Secondary Coverage: Insurance Company Name Insurance Address City State Zip Phone

Subscriber's Name Subscriber's Date of Birth Subscriber's Social Security#

Group/Program Number Subscriber's Employer Employer's Address

1. **What brings you to our office today?**
2. **Do you have any particular concerns?**
3. **What can we do to serve you better?**
4. Tell us your dental history: Ortho Y ☐ N ☐ Bad experiences Y ☐ N ☐ Wisdom teeth removed Y ☐ N ☐

Health History

Patient Name: _____ **Date**_____

Are you having dental pain?_____

Are you in good health?_____

Are you taking any medication: _____**If yes, please list:** _____

_____

Have you been hospitalized in the last 10 years?_____

When was your last physical?_____**Physicians Name:**_____

Do you smoke/chew tobacco?_____**Physicians Phone #**_____

Do you have or are you being treated for:

Y N Allergies to medication _____
Y N Reactions to Local Anesthetics _____
Y N Allergies/Reactions to Antibiotics _____
Y N Asthma, Hay fever or other allergies _____
Y N Cancer: Radiation or Chemotherapy _____
Y N Liver Disease _____
Y N Kidney Disease _____
Y N Heart Disease _____
Y N Stroke _____
Y N High Blood Pressure _____
Y N Heart Murmur _____
Y N Excessive Bleeding _____
Y N Diabetes / Hypoglycemia _____
Y N Epilepsy or Seizures _____
Y N Rheumatic Fever _____
Y N Hepatitis A – B – C _____
Y N Tuberculosis / Lung Disease _____
Y N Are you Pregnant _____
Y N Have you donated blood in the last 10 years
Y N Have you been tested for HIV_____**Date:**_____
Y N Do you have any reason to think you are HIV positive?_____
Medication:_____
Y N Do you have any prosthesis? _____
(Artificial Joints, Heart valves – pacemaker or pins) **Y N**
Depression Therapy _____ **Y N**
Alcohol or Drug related Therapy _____ **Y N**
Pre-Medication Necessary for a Dental Appointment **Type:**_____

I certify that the above information is current and correct and that I will notify this office of any changes.

Patients Signature:_____ **Date:**_____

Dentists Signature:_____ **Date:**_____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (**HIPAA**). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____
Date: _____

Signature: _____

Relationship to Patient: (circle) Self Parent Guardian Other: _____

Spouse, Significant Other or Dependent family members also covered by this acknowledgement:

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

Financial Policy

At **Reign Dental**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to thousands of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

_____ ■ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

_____ ■ We currently accept most private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.**

_____ ■ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, **Reign Dental** reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ ■ **Reign Dental** does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). **We do not accept checks for over $500.00 for any patient**. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, 12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____ ■ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **$55/hour cancellation fee** (emergencies are an exception).

_____ ■ In the event of an emergency after regular business hours a **$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$125 after hours emergency fee. I agree with the above conditions.**

_____ ■ On occasion, **Reign Dental** may have multiple promotions being offered at the same time. Patients will have the opportunity of redeeming one promotion only.

_____ ■ Members of our **Reigny Day Plan** are not eligible for any promotions due to the greatly discounted pricing already included in their membership.

Print Name:_____ Date: _____

Patient/Parent Signature: _____