Scott Condie
DENTISTRY

PATIENT INFORMATION

Patient Name: _____ Date: _____

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Social Security Number: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Best Contact: ☐ Home ☐ Cell ☐ Work

Address: _____ Apt: _____
Street

_____
City State Zip

Whom may we thank for referring you to our practice? _____

In case of an emergency who may we call? _____ _____ _____
Name Relationship Phone

INSURANCE INFORMATION

Primary Insurance:
Name of Insured: _____ Date of Birth: _____

Insurance: _____ Phone: _____

ID Number: _____ Group Number: _____

Employeer: _____ Patient's Relation: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance:
Name of Insured: _____ Date of Birth: _____

Insurance: _____ Phone: _____

ID Number: _____ Group Number: _____

Employeer: _____ Patient's Relation: ☐ Self ☐ Spouse ☐ Child ☐ Other

Medical Insurance:
Name of Insured: _____ Date of Birth: _____

Insurance: _____ Phone: _____

ID Number: _____ Group Number: _____

Employeer: _____ Patient's Relation: ☐ Self ☐ Spouse ☐ Child ☐ Other

NOTICE OF PRIVACY PRACTICES *Purpose: This Notice of Privacy Practices presents the information that the HIPPA Privacy Rules.*

We must provide this Notice to each patient no later than the date of our first service delivery to the patient, after April 14, 2003. We must also have the Notice available at the office for patients to request to take with them. Whenever we revise the Notice, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised notice in our office as discussed above.

We must make a good faith effort to obtain a written acknowledgement of receipt of this Notice from each individual with whom we have a direct treatment relationship and to whom we provide this Notice except in emergency situations. If we do not obtain the acknowledgement, we must document out efforts and the reason we did not obtain the acknowledgement. The last page of the Notice is a written acknowledgement that each patient should sign. We will keep the acknowledgement in the patient's medical record.

Our Privacy practice in its entirety is available upon request. Thank you.

Written Patient Agreement

Please initial on each line below

The information given to us by your insurance company regarding your benefits; however you need to be aware that the information they (your insurance company) provided to us is very limited and is not a guarantee they will cover any procedures. We will provide you with an estimate and your co-pay. Please remember that you, the patient is ultimately responsible for the account and your insurance is only a third party of benefits. The balance and treatment is the patient's sole responsibility and NOT the responsibility of the insurance carrier or the dental office. You will receive a monthly statement to keep you aware of the status of your account. If your insurance has not paid Dr. Scott Condie within 45 business days of treatment, the balance will become the responsibility of the patient.

We will do all that we can do to help our patient's maximize their insurance coverage. We are happy to spend the time that is necessary to do or part to file claims with our patient's insurance company and help you receive the benefits that you are entitled to receive.
Occasionally, the time spent dealing with a patient's insurance company or working on the particulars of your account which may require us to spend time that is far and above the norm. If this is the cause and time out of the norm is needed this may be subject to an administrative fee per hour, for the time spent dealing with your account and/or it's details.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment but the balance is ultimately the patient's responsibility. **Initial _____**

Insurance Are Only Estimates

Any and all estimates you have received from our office are just that…An Estimate! As a courtesy to our patients, we do phone your dental carrier for a breakdown of benefits and that information is reflected on your estimate and employees of this dental office are not responsible for that estimate. Unfortunately, your dental carrier will not guarantee any information given to us; therefore, we cannot guarantee what percentage of your treatment they will cover. We do not base our diagnosis on what your insurance will cover. Diagnosis of treatment is based on your dental health and what the teeth, bone, and/or gums are in need of, in a conservative approach. The patient is ultimately responsible for all charges incurred with our office should your insurance carrier not pay for any reason. **Initial _____**

Financial Agreement

Payment in full for all charges is required at the time of visit delinquent accounts (30 business days or older) are subject to reasonable service charged and/or modest interest rates (based on a 2% interest rate per month). **Initial _____**

Collection proceedings: We want to avoid any possibility of collections for your account, but in the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts will be reversed and you will be responsible for payment of regular fees for procedures at the time of service. **Initial _____**

Missed Appointment Policy

Missed appointments and appointments cancelled without 2 business day notice are subject to a cancellation fee of $50 per half hour of the scheduled appointment time. Any appointment scheduled for 90 or more minutes are subject to a minimum cancellation fee equal to 50% of the procedure(s) fee, some appointments may be subject to 100% of the procedure fee. **Initial _____**

Photography Release

I hereby consent and authorize Dr. Scott Condie and his staff to take photographs, slides and/or videos of my face, jaws and teeth. I understand that the photographs, slides and/or videos will be used as a record of my care and my be used with or without my given name or with a fictitious name for education purposes in lectures, demonstrations, advertising, professional publications (dental magazines and journals) and any other lawful purpose. I release and forever discharge Dr. Scott Condie from any claim, demands or liability on the account of such use of for the quality of the production of the image.
Initial _____

Patient Name: _____

Signature of Patient/Guardian: _____ Date: _____

I, _____, parent or guardian, hereby consent to the information stated above.

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

Please check those that apply and check NO if they do NOT apply

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Glaucoma	☐	☐	Nervous Disorders
☐	☐	Allergies	☐	☐	Grind or Clench Teeth	☐	☐	Pacemaker
☐	☐	Anemia	☐	☐	Hay Fever	☐	☐	Radiation Treatment
☐	☐	Angina	☐	☐	Heart Attack	☐	☐	Respiratory Problems
☐	☐	Arthritis	☐	☐	Heart Surgery	☐	☐	Rheumatic Fever
☐	☐	Artifical Joints	☐	☐	Heart Palpations	☐	☐	Rheumatism
☐	☐	Asthma	☐	☐	Heart Surgery	☐	☐	Rheumatic Fever
☐	☐	Blood Disease	☐	☐	Heart Valve	☐	☐	Seizures/Convulsions
☐	☐	Blood Transfusion	☐	☐	Heart Murmur	☐	☐	Sinus Provlems
☐	☐	Cancer			*Year Diag_____	☐	☐	Stent
☐	☐	Chronic Cough	☐	☐	Hepatitis	☐	☐	Stomach Problems
☐	☐	Click/Popping of Jaw			*___A ____B ____C	☐	☐	Stroke
☐	☐	Depressed Immune System	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Diabetes	☐	☐	HIV	☐	☐	Tuberculosis
☐	☐	Dizziness	☐	☐	Jaundice	☐	☐	Tumors
☐	☐	Emphysema	☐	☐	Kidney Disease	☐	☐	Ulcers
☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Other: _____
☐	☐	Excessive Bleeding	☐	☐	Lung Disease	☐	☐	_____
☐	☐	Fainting	☐	☐	Mental Disorders	☐	☐	_____

	Y	N	
Do you need to PreMedicate prior to Dental Appointment?	☐	☐	If Yes Explain: _____
Are you Currently Preganant?	☐	☐	
If Yes, Are you currently Breast Feeding?	☐	☐	
Have you had past history of Alcohol, Chemical Dependecy?	☐	☐	

Have you every used any of the following?

☐ Biosphosphnates ☐ Fosamaz,Actonel, Boniva, Aredia or Zometa ☐ Phen-Phen

Are you Allergic to or have you had an adverse reaction to any of the following? *Please check those that apply.*

☐ Local Anesthesia/Novocaine ☐ Penicillin/Antibiotics ☐ Sedatives/Barbiturates ☐ Asprin/Ibuprofen

☐ Codeine/Pain Killers ☐ Latex/Rubber ☐ Other: _____

Please list any medications you are taking including presciption medications, diet drugs, over-the-counter medications, herbal or holistic:

_____ _____ _____

_____ _____ _____

Are you currently under the care of a physician? ☐ Yes ☐ No *If Yes please explain*

_____

_____

Have you ever been hospitalized or had major operations? ☐ Yes ☐ No *If Yes please explain*

_____

_____

When was your last physical? _____

Please continue on the next page

DENTAL HEALTH HISTORY

	Y	N
Are you apprehensive about Dental Treatment?	☐	☐
Have you had problems with previous dental teatment?	☐	☐

If **Yes** Please explain: _____

Do you wear dentures?	☐	☐

How long? _____

Does food catch between your teeth?	☐	☐

If **Yes** Please explain: _____

Do you have difficulty in chewing your food?	☐	☐
Do you experience popping/clicking in your jaw?	☐	☐
Do you have jaw pain?	☐	☐
Do you chew on only one side of your mouth?	☐	☐

If **Yes** Please explain: _____

Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sore in or about your mouth?	☐	☐
Are your teeth Sensitive?	☐	☐
Do you prefer to save your teeth?	☐	☐

How often do you brush your teeth? _____

How often do you floss? _____

Do you have a history of Periodontal Therapy?	☐	☐
Are you happy with your smile?	☐	☐

If you could change anything about your smile, what would it be? _____

_____

Are there any other dental concerns that you are having that you would like for us to know about?

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Patient Signature: _____ Date:_____

Dentist Signature: _____ Date:_____