Michael G. Goode, DDS
General Dentist

NEW PATIENT INFORMATION FORM

NAME: _____ EMAIL: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ SS# _____ - _____ - _____

DOB _____ / _____ / _____ MARITAL STATUS: _____ SEX: _____

REFERRED BY: AD: _____ FRIEND: _____ FLYER: _____ WORK: _____ INS. COMPANY: _____

EMPLOYMENT INFORMATION

OCCUPATION: _____ EMPLOYER NAME: _____ PHONE: _____

INSURANCE COVERAGE

POLICY HOLDER/SUBSCRIBER: _____ DOB: _____ / _____ / _____

RELATION TO PATIENT: _____ SS# _____ - _____ - _____ ID# _____

EMPLOYER NAME: _____ ADDRESS: _____

INSURANCE COMPANY NAME: _____ GROUP #: _____

I have read, verified and consent to the medical history form, consent to dental treatment form, financial policy form and appointment policy included herein. I certify that the following information is true to the best of my knowledge.

(Signature of patient or responsible party) **(PRINT name)** **(Date)**

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MEDICAL HISTORY

NAME:_____

Primary Care Physician:_____ Phone:_____

Have you had or do you currently have any of the following? (**Please circle Y or N for each item**)

Y N Artificial Heart Valve
Y N Artificial Joints
Y N Endocarditis
Y N Congenital Heart Defect
Y N Heart Valve Problems
Y N HIV+/ AIDS
Y N HEP A
Y N HEP B
Y N HEP C
Y N Cancer
Y N Radiation Therapy
Y N Bleeding Disorder
Y N Difficulty Breathing
Y N Pregnant/# of mo.___

Y N Drug Abuse
Y N Immune Problems
Y N Alcohol Abuse
Y N Epilepsy
Y N Fainting Spells
Y N Chest Pain/Angina
Y N Glaucoma
Y N Diabetes type I / II
Y N Heart Attack/Heart Disease
Y N High Blood Pressure
Y N Kidney Problems
Y N Thyroid Problems
Y N Tuberculosis

Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Pace Maker
Y N Psychiatric Problems
Y N Rheumatic Fever
Y N Seizures
Y N Stroke

Y N Other:_____
_____

Are you allergic to or suffer ill effects from any of the following?

Y N Penicillin
Y N Codeine
Y N Dental Anesthetics
Other allergies to medication:
Y N Aspirin
_____

Have you ever taken oral or IV **BISPHOSPHONATES**
(Including, but not limited to: Fosmaz, Zometa, Aredia, Actonel, Boniva, Reclast, Prolia etc.)? **Y N**

Do you have any lumps, sores, or irregular tissue in your mouth? **Y N**

Do you smoke or use tobacco? **Y N**

Please list all medications you are currently taking:

_____

_____

(Signature of patient or responsible party) **(PRINT name)** **(Date)**

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CONSENT TO DENTAL TREATMENT

1. I request and authorize above listed provider of service, and/or such other persons as he may appoint, to perform or assist in the performance of all dental treatment received in this office, including, but not limited to: fillings, extractions, root canals, crowns, bridges, implants, cleanings, impressions, injections, x-rays, periodontal therapy and surgery, including laser treatment. I understand it is my responsibility to ask any additional questions regarding the treatment I receive.

   I understand that there have been no guarantees given or implied of any sort by anyone as to the results that may be obtained.

2. Further, it is understood that unforeseen conditions or circumstances may arise during the course of the treatment. Therefore, I consent to and authorize the performance of any care, procedure, or treatment that the dentist believes necessary or advisable as a result of these unforeseen events or conditions.

I consent to the administration of any anesthetic that the dentist (or his appointees) deems necessary to provide proper treatment, including, local anesthetic, oral sedatives, or nitrous oxide/oxygen. Unlikely but possible risks to dental procedures may include: numbness (temporary or permanent), infection, swelling, bleeding, tissue discoloration, damage to adjacent teeth, fillings, crowns, bridges or implants, nausea, vomiting, allergic reactions, aspiration or ingestion of foreign objects, brain damage, stroke, or heart attack. I further understand and accept that complications may require hospitalization and may even result in death. I understand that sedation will require me to have a patient escort, which is my responsibility to provide. I have been advised that additional and comprehensive information is available to me verbally, in writing and/or via the internet (goodefamilydental.com etc.) regarding procedures, options, risks/complications, prognosis and fees. In addition referral to specialists is always available upon request and may be recommended by our office (a specialist is available for many dental procedures as recognized by the ADA).

- American Board of Dental Public Health (DPH)
- American Board of **Endodontics** (Endo) (common procedures root canals etc.)
- American Board of Oral and Maxillofacial Pathology (OMP)
- American Board of Oral and Maxillofacial Radiology (OMR)
- American Board of **Oral and Maxillofacial Surgery** (OMS)(common procedures extractions and implants etc.)
- The American Board of **Orthodontics** (Orth) (common procedures braces etc.)
- American Board of **Pediatric Dentistry** (Ped) (specialize in treating children)
- American Board of **Periodontology** (Perio) (specialize in treatment for periodontitis, gum disease, common procedures scaling and root planning/"deep cleaning", osseous surgery, implants, tissue grafts, frenectomies, etc.)
- American Board of **Prosthodontics** (Pros) (specialize in complex cases "full mouth reconstruction, dentures, implants crowns, bridges etc)

3. Medications, drugs and prescriptions received from this office may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol, or other drugs. Thus I have been advised not to work, make any legal decision or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs, or until fully recovered from the effects of the same. I am also aware I will need a responsible patient escort for any oral sedation received in this office.

4. I have been given an opportunity to refuse to consent to any and all dental treatment or procedures or any part thereof.

5. I certify that I have read and understand the above. I accept all risk of, if any, in hope of obtaining the desired beneficial results. I acknowledge that the dentist has explained all of the above to me in a manner to allow me to comprehend the consequences of my actions and treatment. Any questions about receiving dental treatment in this office and its attendant risks have been answered fully to my satisfaction.

6. Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

(Signature of patient or responsible party) **(PRINT name)** **(Date)**

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FINANCIAL POLICY

- **Payment is expected at the time of service**. If you have a dental insurance plan your co-payment and deductible are due at the time of service. As a courtesy, we will bill your insurance company for you. Using the information you provide us, we estimate of your dental benefits and the *estimated* amount your dental plan expects you to be responsible for; however, we ***do not guarantee*** dental insurance benefit estimates. **While we help you to maximize your allowable insurance benefit, the insurance contract is between you (the insured) and your insurance company, and does not replace your responsibility for your account with us.** Any balance not paid by the insurance company remains your responsibility, including the balance exceeding usual and customary rates (UCR).

ACCEPTED FORMS OF PAYMENT:

1. Cash, check, debit or credit cards (Visa, MasterCard, AMEX and Discover)
2. Most dental insurance plans
3. Care Credit (A third party patient financing program)

DENTAL INSURANCE:

- **PRIMARY INSURANCE**: We require that all insurance co-pays and estimated patient balance, minus estimated insurance assistance, be paid at the time of service. To do so we must receive an updated copy of your insurance card at your appointment. If necessary, we will submit a pre-treatment "estimate of benefits" request to your insurance company before we schedule your treatment.
- **SECONDARY INSURANCE**: Having more than one insurer **DOES NOT** necessarily mean your dental services will be covered at 100%. As a service we will gladly bill your secondary insurance company. **Any balance not paid by your secondary insurance company remains your responsibility.**

Returned checks are subject to a fee of $**25.00** (per check). In the event that your account is not paid in full, you may be referred to a collection agency. You will be responsible for all the fees incurred for collection of your bill. A charge of 1.5% per month (18% annum) will be charged on balances exceeding 90 days. We are committed to delivering the best quality dental treatment for our patients and we charge what is usual and customary for our area.

Your appointment time is reserved exclusively for you. Any change to your appointment affects many patients. Our office must receive notification at least 24 hours in advance to cancel or change your appointment.

A $35.00 fee may be applied for any appointment cancelled without giving at least 24 hours notice. Also, a $50 deposit will be required to hold future appointments. Your Patient Chart will be available to you or transferred to another office at your request for a $30 fee.

I hereby authorize the release of my information to my insurance carrier regarding my treatment. I also hereby authorize any insurance benefits otherwise payable to me to be paid directly to the dental practice of Michael G. Goode, D.D.S. for services provided. By signing below, I acknowledge that I have read, understand and agree to the terms of this Financial Policy. This agreement stays in force until changed in writing.

(Signature of patient or responsible party) **(PRINT name)** **(Date)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***********You may refuse to sign this acknowledgement***********

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____ _____
Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify):_____
  _____
  _____
  _____

You have the right to receive a copy of the Privacy Policy Notice at your request

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **11/01/2010** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice please contact us using the information at the end of this Notice.

USES AND DISCOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operation. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so.

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	YES		NO
Do you currently have pain in any teeth?			
Would you like to discuss options for replacing missing teeth? (implants, dentures, partial plates etc?)			
Do you have sensitivity to hot/cold?			
Do you grind or clench your teeth?			
Do you snore or have sleep apnea?			
Do you have TMJ pain?			
Would you like help to quit smoking? (prescription medication and counseling)			
Are you interested in home fluoride trays to prevent future cavities?			
We STRONGLY recommend that our patients buy a Waterpik AND an electric toothbrush (either an Oral-B or Sonicare) from their local grocery store or pharmacy. Do you want more information or a coupon for a Waterpik/Oral-B/Sonicare?			
Are you interested in Veneers?			
Are you interested in having straighter teeth through Invisalign?			
Are you interested in having whiter teeth?			
Are you interested in applying for a CareCredit payment plan for your dental treatment (no interest plans may be available)?			

Please be sure to discuss any "yes" answers with the dentist and raise any other questions or concerns you have with us.