FRONTIER DENTAL
IMPLANTS & DENTURES

PATIENT INFORMATION

Patient name:_____

Reason for visit:_____

Previous dentist:_____Referred by: _____

Birth date:_____S.S.#_____If minor, parent/guardian name:_____

Home phone:_____Cell phone:_____Work phone:_____

Mailing address:_____

City:_____State:_____Zip:_____

Email address:_____

Dental Insurance:_____Member ID#:_____Group#:_____

Employer:_____Occupation:_____

Emergency contact:_____

Relationship to Emergency contact:_____

Emergency contact phone:_____

How did you hear about Frontier Dental?:_____

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MEDICAL HEALTH HISTORY

The information provided is important to your dental health.

Do you have or have you had any of the following? (Please check any that apply.)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco?

- Yes
- No

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics (i.e. "Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other medication list (please attach dated list if your medications do not fit on this form)

_____

_____

Do you require antibiotics prior to dental treatment?

- Yes
- No

Women:

- May be pregnant
  If so, expected delivery date:_____
- Taking hormones or contraceptives

Name of your physician: _____
Do you have any disease, condition, or problem not listed above?_____

Please add anything else you would like us to know about:_____

_____ _____
Patient or Guardian's Signature Date

_____ _____
Doctor's Signature Date

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FINANCIAL AGREEMENT

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE.

If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:

1. Cash
2. MasterCard
3. Visa
4. Novus/Discover
5. American Express
6. Care Credit monthly payment plans for qualifying patients

Patients with insurance: The PATIENT is responsible for the ESTIMATE non-covered portion, procedures, and/or deductibles at the time of service. If the insurance company downgrades treatment fees or does not pay after 60 days, we will bill you directly for the fullbalance. If the insurance is terminated or lost before the completion of the procedure, the patient is responsible for the unpaid balance.

Additional Terms:

- 18% annual interest is charged for any unpaid balance.
- A $15 fee is charged for non-payment.
- There is a $50.00 processing charge for an NSF check or returned check.
- There is a nominal charge of $20 for release of copies of x-rays.
- Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a $50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTSLESS THAN 24 HOURS IN ADVANCE.

I,_____, agree to these financial terms. _____ _____
(Printed Name) (Signature) (Date)

If applicable:

I,_____, guardian of above patient, agree to these financial terms.
(Printed Name)

_____ _____
(Guardian Signature) (Date)

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PROSTHODONTIC CONSENT FORM

MUST BE SIGNED BEFORE APPOINTMENT OR APPOINTMENT WILL BE CANCELLED

I, _____ understand that dentistry like medicine that has no guarantee of results. There are many variables that can affect short and long-term success and this is dependent on the individual patient. Each patient has different presenting conditions, health issues, financial needs and aftercare habits. In order to minimize any negative outcomes, once treatment begins complete cooperation is necessary. There **are no refunds or money back guarantees.**

There are **no warrantees for treatment**. We are a quality dental service provider and we do the very best treatments for our patients. It is the responsibility of the patient to adhere to their better judgement and follow best practices to maintain their prosthesis. If you misplace or break your prosthesis at any time after fabrication a new one will have to be made and this will be an additional cost to you with no discounts.

You agree to eat a **soft diet** no matter what your prosthesis is to help preserve your prosthesis. This is not going to be like your regular teeth and you will never be able to function as such.

You are required to maintain **good home care and cleaning** of your prosthesis. If your prosthesis fails you will need it replaced and this cost will be your responsibility.

You recognize that you will **have maintenance visits** to take care of your prosthesis and this will cause additional money as is the case for all dental and medical treatment.

You will need to buy a **hard in office mouthguard** to protect your prosthesis. This is an additional cost.

Complete/Partial Dentures – There will be **2 free denture adjustments within 30 days** after denture fabrication to relieve sore spots. Some patient will need an **immediate reline** of their dentures following complete denture fabrication and if you require this you will be charged an additional fee for this service. If you break your denture or misplace it you will be charged for a new one.

Implant Dentures – There will be **2 free denture adjustments within 30 days** after denture fabrication to relieve sore spots. Some patient will need an **immediate reline** of their dentures following complete denture fabrication and if you require this you will be charged an additional fee for this service. If you break your denture or misplace it you will be charged for a new one. You will be required to pay for **maintenance visits on your implant dentures**. Your retention clips will get loose over time (6 months to 1 year) and may need to be changed. This can vary and that is dependent on your situation. **You will be responsible for the cost for this regardless of when it becomes loose**.

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Fixed Implant bridges, Crowns and Bridges, Cosmetic Dentistry - You will be responsible for keeping them clean and caring for them with regular dental visit. Cleaning of this prosthesis is an additional cost to you. There are no warrantees if they break. All (fixed implant bridges, crowns) patients will be required to purchase a mouthguard that need to be used every day or night as instructed by the doctor. This will help preserve the long-term success of your prosthesis. If you, don't you risk prosthesis fracture.

- All prosthetic work will take time to adapt to. This may take weeks, months or even years. Your comfort, bite and speech will be affected but nearly all patient will adapt to the prosthesis. There are of course no guarantees that you will if you are the person that is outside the norm.

- **You will be charged for each visit after your delivery if you need checks just like a doctor's visit**

- Your individual treatment plan may change during treatment. This is very common as situations may change during treatment that might require us to visit a different treatment option for your best interest. **All work is only an estimate. While it is not common, the treatment plan and cost may change.**

- The doctor is allowed to terminate treatment, at any point, if the patient is non-compliant and does not follow instructions that will lead to a successful outcome. We will provide you with an alternative provider so you can seek care elsewhere if this becomes necessary.

- There is no guarantee that you will be accepted as a patient at the practice for treatment. When you are seen at the consultation visit, the doctor will decide if you are both a good fit to work with each other. A good relationship is needed for better health outcomes.

- If work is started, and you fail to attend your appointments, following that, there is no guarantee that your work will be successful. In most instances additional work is needed to correct a neglected mouth and that can result in additional expense to you.

- You agree that if you fail to attend their appointment or fail to give us **24 hours' notice,** you will be charged a **fee of $50**. This fee will need to be paid before another appointment is booked.

- **You agree if you cancel or fail to attend 2 consecutive appointments even if we are provided notice, no further appointments will be booked and you will be dismissed from the office and will be required to seek care elsewhere. This is at the discretion of the doctor as it shows a pattern of nonattendance and this is not fair to our office and our patients.**

Patient Acceptance Signature: _____ **Date:** _____

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step-parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone

☐ Home Phone Confirmation ☐ Email Confirmation

☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone

☐ Home Phone Confirmation ☐ Email Confirmation

☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**

☐ Text Message ☐ **None of the above** (opt out)

☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.
