DECLERCK
FAMILY DENTAL

Welcome to our practice! We are genuinely pleased that you have chosen us for your dental care. Our practice realizes the importance of referrals and we value them greatly. We are always excited to see new smiles coming through our door!

At your first comprehensive appointment, your doctor will complete a thorough oral examination. This includes a complete review of your medical and dental history, all necessary x-rays and intraoral photos, study models (if necessary), oral cancer screening, periodontal health evaluation, and examination of your teeth and soft tissues. Following this exam, your dentist will discuss their findings with you, develop a treatment plan that you are comfortable with, and then you will be scheduled according to your needs.

Please be prepared for your appointment by completing the new patient registration forms. If you have dental insurance, be sure to provide all requested information to assist us in the benefit verification process. Also, please read over our policy section on dental insurance for more information. If you would like to finance your dental expenses we work with CareCredit and will be glad to provide you with information about CareCredit and how to apply. If you have any questions about finances please feel free to ask us at any time.

We ask that you make every effort to keep your appointments. The chair, team and supplies are reserved just for you on the day of your scheduled appointment. If you need to change your appointment, please call us at least 48 hours prior to your visit.

We very much appreciate your confidence in us and look forward to meeting with you!

Sincerely,

Dr. DeClerck and Team

DECLERCK FAMILY DENTAL

FIRST NAME: _____ LAST NAME: _____ MIDDLE INITIAL: _____

PREFERRED NAME: _____PATIENT IS: POLICY HOLDER: Y / N RESPONSIBLE PARTY: Y / N

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME: _____ CELL: _____ (TEXT MESSAGES YES/NO) **WORK: _____**

EMAIL: _____ (RECEIVE EMAILS YES/NO)

SEX: M / F MARITAL STATUS: MARRIED / SINGLE / DIVORCED / SEPERATED / WIDOWED

BIRTH DATE: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYMENT STATUS: FULL-TIME / PART-TIME / RETIRED STUDENT STATUS: FULL-TIME / PART-TIME

EMERGENCY CONTACT: _____PHONE NUMBER:_____

WHOM MAY WE THANK FOR REFERRING YOU: _____

INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP: _____

DOB: _____ SOCIAL SECURITY NUMBER: _____ NAME OF EMPLOYER: _____

WORK PHONE: _____ ADDRESS: _____

NAME OF INSURANCE CO.: _____ PHONE #: _____

GROUP #: _____ ID #: _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP: _____

DOB: _____ SOCIAL SECURITY NUMBER: _____ NAME OF EMPLOYER: _____

WORK PHONE: _____ ADDRESS: _____

NAME OF INSURANCE CO.: _____ PHONE #: _____

GROUP #: _____ ID #: _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

ARE YOU: POLICY HOLDER PRIMARY INSURANCE POLICY HOLDER SECONDARY INSURANCE POLICY HOLDER

FIRST NAME: _____ LAST NAME: _____ MIDDLE INITIAL: ____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME: _____ CELL: _____(TEXT MESSAGES YES/NO) **WORK: _____**

BIRTH DATE: _____ SOCIAL SECURITY: _____ DRIVERS LICENSE NO.:_____

I HAVE RECEIVED / REQUESTED THE HIPAA PRIVACY POLICY ACT AND I UNDERSTAND MY FINANCIAL RESPONSIBILITIES TO DECLERCK FAMILY DENTAL (SIGNATURE) _____

Medical History New Update 12/7/23

Patient Name: Birth Date: Date Created:

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	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Have you EVER had a joint replacement or heart surgeries? Ex: Knee, Hip, Heart Stent, Heart Surgery	◯ Yes ◯ No	If yes
Do you need a PREMED for a joint replacement or heart surgery? ASK your physician if you are unsure.	◯ 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 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
Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ 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:_____

Dental History:

Date of your last dental visit: _____ Reason for visit:_____

Previous dentist's name: _____ Phone number: _____

Last x-rays taken: 4 bwx (date) _____ Pan/full series: _____

*****DO YOU REQUIRE A PRE MEDICATION PRIOR TO YOUR DENTAL VISITS?***** (Y or N)

If YES, please list reasoning and name of medication: _____

Are you currently having any dental problems? (Y or N)

If YES, please describe: _____

How often do you have dental checkups:

Every 6 months ( ) Once a year ( ) As needed ( )

How often do you brush your teeth: _____ **How often do you floss/use dental aides**: _____

Are you satisfied with your teeth's appearance? (Y or N)

If NO, please explain: _____

Would you like to keep your teeth for the rest of your life? (Y or N)

Do you feel nervous about having dental treatment? (Y or N)

If YES, please explain: _____

Are any of your teeth sensitive to: ___ HOT ___ COLD ___ SWEETS ___BITING ___CHEWING

Have you noticed any bad odors or bad taste in your mouth? (Y or N)

Do your gums bleed or hurt? (Y or N)

Do you frequently get cold sores, blisters or any other oral lesions? (Y or N)

If YES, please explain: _____

Have yourself or a family member experienced any of the following? ___GUM DISEASE ___TOOTH LOSS

Have you ever had: ___ORTHODONTIC TREATMENT ___PERIODONTAL TREATMENT ___ORAL SURGERY

Please check the following that apply to you:

___ Clench/grind teeth ___ Bite lips/cheeks

___ Notice jaw pain/clicking or popping ___ Experience headaches/neck aches/shoulder aches

Please explain any other dental concerns you may have:

DECLERCK FAMILY DENTAL

Thank you for choosing us for all of your dental needs. We are committed to providing you with excellent care. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees, our patient's financial capabilities and your full understanding of the content of this form.

PAYMENT

Payment in full is due for your copay at the time services are rendered unless prior financial arrangements are made. We offer several payment options including:

- Cash, Checks, Visa, MasterCard, Discover and Care Credit
- We offer pre-payment discounts for patients that do not have dental insurance that pay at the beginning of treatment.
- We offer monthly payment plans in accordance with the office credit guidelines.

Please initial _____

INSURANCE

Our office is committed to helping our patients maximize their benefits. As you may be aware, medical and dental insurance is becoming increasingly complex. We are always available to answer your questions. However, your insurance policy is a contract between YOU and YOUR INSURANCE COMPANY and as a dental service provider, we are NOT PARTY to that agreement. The patient portion of your bill MUST BE PAID at the time of service. We ask that our patients provide us with COMPLETE dental insurance information. As a service to you, we will bill your insurance company for services and will allow 45 days to render payment in full. AFTER 60 DAYS, you are responsible for the entire balance which is due in full upon request. Insurance policies vary considerably. We try to ESTIMATE your coverage in good faith, but cannot GUARANTEE COVERAGE or payment amounts by your insurance company. THIS IS AN ESTIMATE ONLY.

Please initial _____

MINORS

Payment of service for treatment of minors is the responsibility of the adult accompanying that minor at the time of service unless prior arrangements are made.

Please initial _____

RESERVED APPOINTMENTS

Once you have made an appointment, please remember that this time has been reserved specifically for you. We are aware of how important your time is, and we ask that should you need to change an appointment, that you kindly give **48 hours notice. We do reserve the right to charge a cancellation fee of $75.00.** *There are also times when prime appointments may require a nonrefundable reservation fee to hold this time for you.*

Please initial _____

SERVICE CHARGE

It is the policy of this office to charge 1.5 monthly (18% annual percentage rate) fee with a minimum $2.00 charge to all accounts which are over 60 days past due. We will charge a fee of $35.00 for each returned check.

Please initial _____

COLLECTION FEE

We try our best to minimize the use of outside sources to aid in the collection of fees incurred in our office but occasionally it is necessary for us to utilize such a company. Any account that is over 60 days past due may be scheduled for collection. If an account is referred to a collection agency for retrieval of payment, any discounts or previous professional adjustments given will be forfeited by the patient and these monies will be added back onto the account. In addition, all expenses relating to such collection will be charged to the person with financial responsibility for the patient's account. The minimum fee charged for collection of an account is $50.00.

Please initial _____

FINANCIAL CONSENT

The patient (or person responsible for the account) agrees to be fully responsible for the total payment of treatment performed in this office.

Please initial _____

I fully understand and agree to all terms in this office policy.

Names of patients that are the responsibility of the signer (PLEASE PRINT)

_____

_____

Signature of patient (or if minor, responsible party):

_____ Date: _____

DECLERCK FAMILY DENTAL

HIPAA

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

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and in-directly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

Signature: _____

Print Name: _____

*****PLEASE SIGN PATIENT INFORMATION SHEET*****
THAT YOU HAVE READ AND RECEIVED A COPY
OF THE HIPAA CONSENT FORM AND
FINANCIAL OBLIGATIONS.
THANK YOU

DECLERCK FAMILY DENTAL

I, _____, give my consent for my information, dental and personal, to be shared with the following:

Name: _____ **Relationship**: _____

Phone Number: _____

Name: _____ **Relationship**: _____

Phone Number: _____

Name: _____ **Relationship**: _____

Phone Number: _____

Name: _____ **Relationship**: _____

Phone Number: _____

Patient/Guardian Signature:

_____ Date: _____