Patient Name ______________________________ **Date of Birth** ____________

Sex: • Male • Female **Marital Status:** • Single • Married • Divorced • Widow

Address _______________________ **City** ____________ **State** ____ **Zip** ______

Home Phone ____________ **Cell Phone** ____________ **Work Phone** ___________

Email Address ____

Patient Employer _________________ **Employers Address** _________________

City ____________ **State** ____ **Zip** ______ **Patient SSN** _________________

Referring Physician/Office _________________________ **Phone** ____________

Responsible Party Name ______________________ **Date of Birth** ____________

Address ______________________ **City** _____________ **State** ____ **Zip** ______

Home Phone ____________ **Cell Phone** ____________ **Work Phone** ___________

Employer _____________________ **Employers Address** ____________________

City ____________ **State** ____ **Zip** ______

Dental Insurance Carrier __________________________ **SSN** _____________________

Insurance ID # __________________________ **Group #** _____________

Insurance Address _______________ **City** _____________ **State** ____ **Zip** ______

Medical Insurance Carrier __________________________ **SSN** _____________________

Insurance ID # __________________________ **Group #** _____________

Insurance Address _______________ **City** _____________ **State** ____ **Zip** ______

Emergency Contact Name _________________**Relationship** _________**Phone** __________

Please have your driver's license and insurance card available for us to make a copy for your records.

I hereby authorize payment of medical/dental benefits to Rock Dental Brands for services rendered and agree that the entire bill is my responsibility, regardless of what my insurance coverage may be. Once my dentist obtained my one-time authorization, he may submit and later claim on assigned or unassigned basis without obtaining any additional signature.

Payment is due the day services are rendered.

____________________________________ ______________

Patient/Legal Guardian Signature **Date**

HEALTH QUESTIONNAIRE

Please mark all that apply

1. CARDIOVASCULAR DISEASE

- Low Blood Pressure
- High Blood Pressure
- Arteriosclerosis
- Heart Attack
- Heart Bypass Surgery
- Prosthetic Heart Valves
- Congenital Heart Malformations
- Hypertrophic Cardiomyopathy
- Mitral Valve Prolapse
- Heart Murmur
- Rheumatic Fever
- Bacterial Endocarditis
- Heart Stents or Shunts
- Osteoporosis
- Other ______________________________

2. OTHER

- Diabetes, taking insulin?
- Insulin name:
- Blood transfusion since 1980?
- Hepatitis: A B C
- Jaundice, liver disease
- Stomach Ulcers
- Kidney Problems
- Arthritis or Rheumatism
- Tuberculosis
- Venereal Disease or AIDS virus
- Abnormal Bleeding
- Anemia
- Cancer: Radiation / Chemotherapy
- Have you had any joint replacements?
- Are you pregnant? How many months?
- Sinus trouble
- Hay Fever
- Asthma
- Cocaine use
- Stroke
- Angina / Chest Pain
- Irregular Heartbeat
- Pacemaker / Implanted Defibrillator
- Autoimmune Disease / Lupus
- Thyroid Disease
- Organ Transplant
- Epilepsy / Seizure
- Psychiatric Treatment
- Emphysema / Bronchitis
- Other ____________________________

3. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Penicillin / Antibiotics
- Sulfa Drugs
- Codeine
- Iodine
- Aspirin
- Local Anesthetic

4. ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

- Sulfa Drugs
- High Blood Pressure
- Tranquilizers

MEDICATION LIST:

List any other medications you are taking currently:

____

____

____

- Aspirin
- Antihistamines
- Cortisone
- Digitalis
- Drugs for Heart Disease
- Antibiotics

  Names of Antibiotic: ______________________

  Date Started: ____________________
- Vitamins and/or Herbals
- Appetite Suppressants

____

____

____

5. ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?
Fosamax, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefos, Zometa?

____

____

____

6. HAVE YOU HAD ANY PROBLEMS ASSOCIATED WITH PREVIOUS DENTAL TREATMENTS?

____

____

____

7. HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS IN THE PAST?

____

____

____

____
Patient Name

____ ____________________
Patient/Legal Guardian Signature **Date**

OFFICE FINANCIAL POLICY

Payment is due in full at the time services are rendered. We will give you an estimated percentage your insurance will not cover at the time of service. If for any reason your insurance company should pay less than the estimated amount, the remaining balance will be your responsibility.

If you are not insured, payment is due the day services are rendered. We will require the full amount unpaid by insurance on the day services are rendered and we will bill your insurance company for the difference. Our policy is to allow a 30-day grace period from the date of services rendered for your insurance company to pay the difference.

Once your account reaches 30 days past due the balance becomes your responsibility and is due immediately. If you fail to pay your account in full or if satisfactory payment arrangements are not timely made and timely payments are not made pursuant to the payment arrangement within 90 days following your office visit, we may refer your account to our collection agency. Your account could be reported to the credit bureau.

Services provided by others (laboratories, etc.) outside of this practice are not part of the treatment fee and are your responsibility

PAYMENT TYPES | We accept cash, check, Visa, MasterCard, Discover and American Express as payment in our office. We charge $30.00 on all returned checks.

CARE CREDIT | Care Credit is a third-party dental/medical lender. We offer this as a payment plan option and can assist you with this application if you so choose.

By signing below, I hereby consent to the taking of x-rays, photographs, and other necessary records before, during and after treatment and to the use of same by this practice for any reasonable purpose.

By signing below, I authorize the release to my insurance company or companies any information including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for the treatment provided.

You agree, for us to service your account or to collect any amounts you may owe us, we may call you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that Rock Dental Brands or affiliated collection agency may contact me as described above.

____________________________________ ________________
Signature of Patient/Parent/Guardian Date

PHOTO AND VIDEO RELEASE

I hereby grant Rock Family Dental the right and unrestricted permission to use photos/videos taken of me (or my child), or in which I (or my child) may be included with others, and to use, reuse, publish, and republish the same in whole or in part, individually or in conjunction with other photos/videos and in conjunction with any media now or hereafter known, and for any purpose whatsoever for illustrations, promotion, art, editorial, advertising, and trade, or any other purpose whatsoever without restriction.

____________________________________ ________________
Signature of Patient/Parent/Guardian Date

APPOINTMENT POLICY – SURGERY SCHEDULING

Please be advised that when a surgery is scheduled for you that includes intravenous anesthesia (IV), we are reserving a time slot specifically for you, as well as for a Nurse Anesthetist. We must remit payment to the Nurse Anesthetist regardless of changes you may need to make to your surgery schedule. If you are not able to keep your originally scheduled appointment, you may be charged a $250 change fee to cover this expense. Please note, failure to keep original appointment could result in a longer wait for a new surgery date. We are happy to reschedule, if necessary, but we require a minimum of 48-hours' notice.

If the patient is a minor, I understand that a legal guardian must be present at the new patient appointment and all treatment appointments. Any person bringing the patient to an appointment must be added to the patient's HIPAA form by the legal guardian prior to the appointment.

Signature of Patient/Parent/Guardian   Date

TEXT AND EMAIL POLICY

Rock Dental Brands can email and/or text your appointment reminders and general information about our services. If you would like to receive communications via email or text in the future, please read and sign the consent attached below.
You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. By executing this consent, you assume the risk that information contained in any such communication will be intercepted. We will not charge you for sending texts or emails, but chargers from your carrier may apply. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and communications sent by our practice until I request a change in writing.

Communication Preference (Please Circle One)   Email   Text

Signature of Patient/Parent/Guardian   Date

CONSENT TO RECEIVE TREATMENT

Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of any necessary anesthetics, sedatives, and other medications. I fully understand that using any medications can involve certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature of Patient/Parent/Guardian   Date

NOTICE OF PRIVACY POLICY

We care about your privacy and the privacy of your personal health information. By law, we are required to maintain your privacy, and to give you notice of our privacy policies and practices, if requested. Our Privacy Policy is displayed in our offices, can be viewed on our website, and a printed copy is available upon request.

Please list below any person who can receive PHI (Protected Health Information) on this patient.

Name	Relationship	Treatment Info		Ledger	
____________________	____________	Yes	No	Yes	No
____________________	____________	Yes	No	Yes	No

______________________________________ Signature of Patient/Parent/Guardian

______________ Date