Medical History Information

1. Describe your current dental problem(s)?_____

_____

2. Are you having pain or discomfort at this time? ☐Yes ☐No
3. Have you been a patient in the hospital during the past two years? ☐Yes ☐No
4. Have you been under the care of a medical doctor during the past two years? ☐Yes ☐No

   Physician's Name_____ Phone Number _____

   Address_____
5. Have you taken any medication or drugs in the past two years? ☐Yes ☐No
6. **Are you now taking any medication or drugs? (includes medication for pain, recreational drugs, and hormones)** ☐Yes ☐No

   If yes, please list:_____
7. **Are you currently taking any type of Herbal Supplements?** ☐Yes ☐No

   If yes, please list:_____
8. **Are you sensitive or allergic to any medication or anesthetics?** ☐Yes ☐No

   If yes, please list:_____
9. Have you ever taken the diet drug Phen-Phen? ☐Yes ☐No
10. Indicate which of the following you have had or have at the present. Check "yes" or "no" for each item.

Heart Failure	☐Yes ☐No	*Artificial Joints (hip, knee, etc.)	☐Yes ☐No	Hepatitis B (serum)	☐Yes ☐No
Heart Disease or Attack	☐Yes ☐No	Kidney Trouble	☐Yes ☐No	Hepatitis C	☐Yes ☐No
Angina Pectoris	☐Yes ☐No	Ulcers	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Congenital Heart Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	A.I.D.S.	☐Yes ☐No
*Heart Murmur	☐Yes ☐No	Thyroid Problems	☐Yes ☐No	H.I.V. Positive	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Glaucoma	☐Yes ☐No	Cold Sores/Fever Blisters	☐Yes ☐No
Arteriosclerosis	☐Yes ☐No	Cancer	☐Yes ☐No	Hemophilia	☐Yes ☐No
*Mitral Valve Prolapse	☐Yes ☐No	Emphysema	☐Yes ☐No	Anemia	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Chronic Cough	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
*Heart Pacemaker	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Bruise Easily	☐Yes ☐No
Heart Surgery	☐Yes ☐No	Asthma	☐Yes ☐No	Liver Disease	☐Yes ☐No
*Rheumatic Fever	☐Yes ☐No	Hey Fever	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Arthritis	☐Yes ☐No	Allergies or Hives	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No
Rheumatism	☐Yes ☐No	Sinus Trouble	☐Yes ☐No	Fainting or Dizzy Spells	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Radiation Therapy	☐Yes ☐No	Nervousness	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Tumors	☐Yes ☐No
Stroke	☐Yes ☐No	Hepatitis A (infectious)	☐Yes ☐No	Developmentally Disabled	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Breathing Problems	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No
Blood Disease	☐Yes ☐No	Shortness of Breath	☐Yes ☐No	Excessive Thirst	☐Yes ☐No
Hypoglycemia	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Alzheimer's Disease	☐Yes ☐No

11. Do your ankles swell during the day? ☐Yes ☐No
12. Have you lost or gained more than 10 pounds in the past year? ☐Yes ☐No
13. Are you on a special diet? ☐Yes ☐No
14. Do you have or have you had any disease, condition, or problem not listed? ☐Yes ☐No

    If yes, please list:_____
15. Do you use tobacco products? ☐Yes ☐No
16. Do you use alcohol products? ☐Yes ☐No

FOR WOMEN ONLY:

17. Are you pregnant? ☐Yes ☐No If yes, what month?_____ Are you nursing? ☐Yes ☐No
18. Are you taking birth control pills? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

PARENT OR RESPONSIBLE PARTY _____ **RELATIONSHIP TO PATIENT** _____

Medical Review: Reviewed by:_____ Date_____ Medical History Update by Patient: Initials_____ Date_____

Reviewed by:_____ Date_____ Initials_____ Date_____
Reviewed by:_____ Date_____ Initials_____ Date_____

Patient Information

Name: _____ Phone:_____ Wk Phone: _____

Email Address _____ Date of Birth:_____ Social Security #_____

Home Address: _____ City: _____Zip Code: _____

Insurance Company:_____ Insured's Employer:_____

Who is responsible for this bill? _____

Spouse's Name: _____ Phone: _____

Whom may we contact in case of an emergency?

_____ Phone: _____

Whom may we thank for referring you to us?

_____ Phone: _____

PRIVACY POLICY

As dental professionals, Dr. Frandsen and his staff implemented this Health Information Privacy Policy and Procedures to protect the interest of our patients and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the amended modifications of 2002 and state law that provide greater information are important to us.

We will not use your health information for marketing communications. We may release your health information:

- To other dental specialists if you are referred
- To provide you with appointment reminders
- To you or to anyone you designate in writing
- To obtain payment for services we have provided for you
- When required by law

As a patient you have a right to view or transfer your dental records for a fee.
We support your right to the privacy of your health information.

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

I acknowledge that I have been given the opportunity to read and become familiar with the privacy policies of Horizon Dental Associates. I agree to the terms and conditions stated therein.

Patient/Guardian Signature

Date

CONSENT TO PROCEED

I authorize the Doctors of Horizon Dental Associates and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause untoward reactions or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complications of non-healing of the jawbones following oral surgery.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: X _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Staff Witness: _____ Date: _____

FINANCIAL AND INSURANCE POLICIES

Our Commitment

At Horizon Dental, we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

We understand how valuable your time is, so we make every effort to remain on time. We feel that you deserve our complete and focused attention so that we may provide the best care possible.

Your Commitment

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Your portion of your treatment is expected at the time of your services. For your convenience we do accept many forms of payment including: cash, check, Visa, Mastercard, American Express, and Discover Card. We offer 3rd party financing through Care Credit, which includes both interest free programs and extended financing. We also offer an in office discount plan for patients who do not have dental insurance. Please ask for more details.

INSURANCE

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. At the time of service we will ask you to pay your estimated co-payment. Please understand that this is only an estimate, and is based upon the information available to us.

Insurance benefit coverage depends solely on what your employer wishes to purchase. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies.

The **financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office.** We will assist you in any way we can. Any amount owing after your insurance company has paid will be due from you upon receipt of our statement. Should your account be referred to an attorney or collection agency, you will pay all cost of collection, including up to 40% collection fee, as well as court costs and a reasonable attorney fee.

We have a 24 hour cancellation policy. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if a 24 hour notice is given. If sufficient notice is not given, your account will automatically be charged a $50 missed appointment fee.

I allow the below signature to be held as a signature on file for all insurance claims and/or telephone/mail/credit card payments.

Patient/Guardian Signature _____ Date_____

Parent or Responsible Party _____ Relationship to Patient _____

WE ARE PLEASED TO HAVE YOU AS OUR PATIENT

Assignment of Benefits Form

I,_____, understand that services rendered to me by Horizon Dental Associates are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Horizon Dental Associates and I understand that I will be fully responsible for any outstanding balance on my account. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Horizon Dental Associates within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violation of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Horizon Dental Associates to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness_____

_____ _____

Signature of Policyholder Patient or Guardian

Practice Name:_____ Date:_____

Address:_____ Patient:_____

City, State, Zip_____ ID#_____

Phone:_____ Group#_____