Safe Harbor Dental

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502 Bud Drive | STE 102 • Chesapeake, VA 23322 (757)547-0222

Welcome to Safe Harbor Dental

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitus
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervious Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rhumatic Fever
- ☐ Rhumatism
- ☐ Sinus Problems
- ☐ Stomache Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Subject to frequent headaches
- ☐ A smoker or smoked previously
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician, their specialty, and phone number:

_____

_____

Date of most recent physical exam and purpose for exam:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

List all medications, supplements, and/or vitamins taken within the last two years:

_____

_____

☐ * **By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

_____

_____

Date of most recent dental exam: _____ **Date of most recent dental x-rays:** _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What brings you to the office today?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint
☐ You have any problems chewing
☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
☐ Your teeth crowding or developing spaces
☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
☐ You clench you teeth in the daytime or make them sore
☐ You have problems with sleep or wake up with an awareness of your teeth
☐ You wear or have worn a bite appliance

Health History Certification

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect or inaccurate information has the potential of being hazardous to my health.

Signature _____ **Date** _____

Notice of Privacy Practices Acknowledgement

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 the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 Private 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 health care 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.

Signature _____ **Date** _____

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature _____ **Date** _____

Authorization and Consent for Service

I hereby authorize and give my consent for Dr. Spinden and her staff to administer such medications and perform such diagnostic and dental treatments as may be necessary for proper dental care. I understand that during treatment it may be necessary to change and add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being a root canal therapy, following routine restorative procedure. I give my permission to the dentist to make any or all changes and additions as necessary.

Patients without dental insurance understand the payment for the office visit, consultation, or any procedure is expected the day the service is provided.

Patients with dental insurance understand that all dental services are charged directly to the patient and that they are personally responsible for payment of all dental services. Dental insurance is an agreement between you and your insurance carrier. Please also understand that we do not participate with all insurance providers.This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. It is your responsibility to verify with your insurance carrier that services performed or proposed by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office. Additionally, it is your responsibility to pay the Practice for any deductible, co-payments or non-covered charges.

I authorize Dr. Spinden to release any information including the diagnosis and record of treatment or examinations for myself and my dependent(s) to third party insurance carriers, payors, and/or healthcare practitioners via email, fax, telephone, or internet. I authorize my insurance carrier to submit directly to Dr. Spinden so it may be applied directly to my account. However, if we are not a participating provider with your insurance, and payment is directed to you, it is your responsibility to provide payment to our office.

I understand that I am financially responsible for any outstanding balances for service and materials provided that are not covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on the behalf of my dependent(s) if any.

If you pay by check and your check is returned for any reason, you will be charged a $35.00 processing fee by us, as well as whatever fees your bank assesses.

All accounts not paid in full within sixty (60) days of the date of service shall incur a financial charge in the amount of two percent per month (24% per annum) on the unpaid balance from the date of service. If this dental office refers this account for collections, the patient and/or responsible party shall be responsible for all costs of collections, including attorney's fees (33-1/3% of the amount referred for collection), court costs and any other associated collections costs.

Should you need to make payment arrangements, or have any questions regarding your bill, please call our office. We are more than willing to work with you to resolve your balance.

Signature _____ **Date** _____

Appointment Policy

As a courtesy to our valued patients, especially those who are waiting to schedule an appointment, we ask that all our patients make every effort to notify this office as soon as they discover that they cannot be present at their appointment. If a patient does not arrive for their scheduled appointment and does not give at least 48 hours notice that they cannot be present at their appointment, there will be a $50.00 non-refundable fee required to schedule another appointment. This $50.00 will be applied toward the fee for their next appointment. If the rescheduled appointment is also failed without 48 hours notice, the $50.00 fee will not be refunded.

We continue to strive to deliver the finest dental care possible in a friendly, professional environment. Thank you for supporting our practice and please know how much we value your loyalty

Signature _____ **Date** _____

Response Date: _____