Partners in DentalHealth

Virginia Beach Norfolk

Serving Hampton Roads for more than 30 years

Patient Information

Today's Date: ___/___/_____

Patients Name: _____

First MI Last

Address: _____

_____

City State Zip

Email: _____

Phone# (H) (____) -_____

Phone# (C) (____) -_____

Phone# (W) (____) -_____ Ext: ____

Birth Date ____/_____/_____

SS# _____

Title:_____ Preferred Name:_____

Spouse's Name: _____

Referred By:_____

Appointment Reminders:

☐ By Phone ☐ By Email ☐ By Text

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Dental Insurance

Insurance Name: _____

Address: _____

_____

City _____ State _____ Zip_____

Phone # (____) _____

Group # (Plan, Local, or Policy #) _____

Subscriber's Name _____

Relation: _____ Date of Birth __/__/_____

Subscriber's ID# _____

Subscriber's Employer: _____

Secondary Dental Insurance

Insurance Name: _____

Address: _____

_____

City _____ State_____ Zip_____

Phone # (____) _____

Group # (Plan, Local, or Policy #) _____

Subscriber's Name _____

Relation: _____ Date of Birth __/__/_____

Subscriber's ID# _____

Subscriber's Employer: _____

Office use

Medications currently taking: ☐ None ☐ Insulin ☐ Blood Thinners (including aspirin) ☐ Muscle relaxers ☐ Pain Killer

_____

_____

Have you ever taken: Osteoporosis Meds (ex. Aredia/Fosamax) ☐ Yes ☐ No

Surgery and Medical Conditions: ☐ None _____

Have you ever had a prosthetic repair to your heart? ☐ Yes ☐ No

Y N Heart Attack/Stroke	**Y N** Chemotherapy	**Y N** Sinus Problems
Y N Heart Surg./Pacemaker	**Y N** Radiation Therapy	**Y N** Stomach Ulcers
Y N Heart Murmur	**Y N** Artificial Joints	**Y N** Jaw Problems
Y N Artificial Valves	**Y N** Arthritis/ Rheumatism	**Y N** Severe Frequent Headaches
Y N Heart Disease	**Y N** Thyroid Problems	**Y N** Drug Abuse
Y N Congenital Heart Defect	**Y N** Kidney Problems	**Y N** Seizures/ Epilepsy
Y N Chest Pains	**Y N** Liver Problems	**Y N** HIV+/AIDS/ARC
Y N High/Low Blood Pressure	**Y N** Hepatitis	**Y N** Psychiatric diagnosis
Y N Bleeding Problems	**Y N** Asthma	**Y N** Diabetes
Y N Anemia	**Y N** Emphysema	
Y N Cancer	**Y N** Tuberculosis	

Allergies: ☐ None ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Seasonal ☐ Food _____

_____

Do you use tobacco? ☐ Yes ☐ No Type _____

Are you currently under the care of a Physician? ☐ Yes ☐ No

Physician _____ Phone # _____

Emergency Contact _____ Phone # _____

Has your dental insurance changed in the last 6 months? ☐ No ☐ Yes ☐ No Insurance

For Women:

Are you pregnant? ☐ Yes ☐ No duration_____ nursing ☐ Yes ☐ No

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Name _____ Email Address _____

Current Address _____ Phone _____

Signature _____ Date ____/_____/_____

PARTNERS IN DENTAL HEALTH

Our team at Partners in Dental Health is committed to providing the best dental care for your particular needs. We are part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top-quality care as cost effective as possible. To assist with your health care investment, we provide the following payment options: Cash or Check, Major Credit Cards (MasterCard and Visa), or Care Credit.

Payment is due at the time of treatment. To enable you to proceed without delay, our office offers several financial options. We encourage you to select a financial arrangement that best suits your budget.

A Returned Check Fee of $25.00 will be charged for any check returned for insufficient funds ____ **(INT)**

All account balances over 60 will be assessed a handling charge of 1.5% per month (18%APR). All accounts over 90 days will be transferred to a collections agency. At that time, all costs of collection, including attorney and legal fees, will be added to your account balance.

Insurance Policy

Our goal is to maximize your insurance benefits and make any remaining balance easily affordable. Please be prepared to show your insurance card and driver's license at the time of your visit. If the patient has any insurance changes, it is the patient's/guarantor's responsibility to provide the new information. If this information is not provided at the time of service, the patient/guarantor will be responsible for all charges incurred. _____ **(INT)**

I understand my dental insurance is a contract between the insurance carrier and myself; not between Partners in Dental Health and the insurance carrier. As a courtesy, Partners in Dental Health will gladly submit your insurance to your primary and/or secondary insurance. The patient/guarantor is responsible for their estimated portion and additional fees at the time of service. Please be aware that some insurance companies may not cover all services performed in our offices. If for some unforeseen reason your insurance payment is not paid within 60 days, the patient/guarantor is responsible for the charges that are denied or unpaid by insurance**.** Most insurance companies will not pay for composites (white fillings) on posterior teeth. Instead, they pay their allowance for an amalgam (silver filling). You are responsible for the difference. Please keep this in mind as here at Partners in Dental Health, we do not do amalgam fillings. ____ **(INT)**

Authority of Treatment

I hereby grant authority to Dean E. Kent DDS PC; Keenan M. Davis DDS PC; John W. Kent, DDS, and/or Mathew E. Kent DDS PC to the dentist(s) in charge of my care, to administer any treatment, to administer such anesthetics, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my case.

In the event the doctor of a team member is punctured by a sharp instrument, I agree to have my blood tested. I acknowledge that I have been informed of the risk and possible consequences of the treatment proposed and do authorize the above name doctor(s) to proceed. ___ **(INT)**

Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with minimum of 1 business days notice. Our office does not accept cancellation or changes in appointment after hours by voicemail: you must call during business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist.___ **(INT)**

Office Hours

Monday through Friday 8AM to 5PM
Some Saturdays

Missed Appointment Fee:

Missed appointment fee of $25.00 will be charged to any patient who does not notify our office within one business day to cancel or reschedule their appointment.___ **(INT)**

HIPPA Privacy Practices

We practice standard HIPPA policies and provide a pamphlet to you of our office policies to protect the patient and sensitive information.

I have read and agree to the policies and received notice of Privacy Practices

_____

Patient's Name (print)

_____ _____

Patient or Parent Signature Date