WELCOME! Thank you for choosing Haas Dental Associates for your dental health care needs. We promise to do our best to provide you with the finest care available. Our team is committed to making your treatment both a pleasant and successful experience. If you have any questions, need assistance completing these forms, or there is anything we can do to make your visit with us more comfortable, please let us know.

PATIENT INFORMATION

Name: _____ Date: _____ DOB: _____

Please Circle: Married Single Widowed Gender: Male Female

Email: _____ Social Security #: _____

Phone: Home (____) _____ Cell: (____) _____ Work: (____) _____

Preferred Method of Contact (please circle) Home Phone Work Phone Cell Phone Email Text

Physical Address: _____
Street Apt # City State Zip

Mailing Address: _____
(if different than above) Street Apt # City State Zip

HOW DID YOU HEAR ABOUT US?

Please Circle: Friend Relative Internet Sign Insurance Other

Name of referral source: (which friend, relative, search engine, etc.) _____

INSURANCE INFORMATION

Primary Dental Insurance - Who is the subscriber: _____ Subscriber's DOB: _____

ID#: _____ Group #: _____ Insurance Plan Name: _____

Address: _____ Insurance Plan Phone #: (____) _____

EMPLOYER NAME: _____ Occupation: _____

Secondary Dental Insurance – Who is the subscriber: _____ Subscriber's DOB: _____

ID#: _____ Group #: _____ Insurance Plan Name: _____

Address: _____ Insurance Plan Phone #: (____) _____

EMPLOYER NAME: _____ Occupation _____

MEDICAL HISTORY

Patient name: _____ Age: _____ Date: _____

Emergency Contact (Name/Phone Number): _____

Name of Physician: _____ Physician Phone #: _____

Date of last visit to Physician: _____ Rate your general health: POOR FAIR GOOD

1: Please list ALL medical conditions you have been diagnosed with by a physician: _____

2: Please list ALL medications, vitamins, herbal supplements, or dietary supplements you are currently taking:

3: Do you now, or have you previously, taken any of the following medications? (Please circle all that apply):
Coumadin/Warfarin Plavix Fen-phen/Redux/Pondimin Bisphosphonates (Fosamax, Boniva, Actonel, Zometa, Aredia)

4: (Women) Are you currently pregnant, trying to get pregnant or nursing? ……..
Yes No

5: Do you take oral contraceptives?..... Yes No

6: Are you allergic/sensitive to (please circle): NONE CODEINE PENICILLIN LOCAL ANESTHETIC LATEX DYES

Please list any other allergies you are aware of: _____

7: Do you smoke or chew tobacco?
…….. Yes No

If yes, which one and for how long? _____

8: Do you have Diabetes?
……. Yes
No

If yes, please indicate: TYPE 1 TYPE 2 Last HbA1c date and level: _____

9: Do you have, or have you ever had:

	Y	N		Y	N		Y	N
Epilepsy/Seizures			Glaucoma			Hay Fever/Hives/Skin Rash		
Hearing Impairment			Heart Attack			Heart Pacemaker		
Heart Problems			Heart Surgery			Hepatitis (Indicate Type)		
High Blood Pressure			HIV Positive/AIDS			Jaundice		
Kidney Disease/Dialysis			Liver Disease			Low Blood Pressure		
Mood Disorder/Emotional Problems								

Osteoporosis		
Pain in Jaw Joints		
Prolonged or Excessive Bleeding		
Psychiatric Care		
Recreational Drug Use		
Respiratory Problems		
Rheumatic Fever		
Scarlett Fever		
Sinus Problems		
STD		
Stroke		
Thyroid/Parathyroid Problems		
Tuberculosis		
Ulcers/GERD		

Alcohol or Drug Dependency		
Anemia/Bleeding Disorder		
Arthritis		
Artificial Heart Valve/Stent		
Artificial Joints		
Asthma		
Cancer		
Chemotherapy/Radiation		
Cold Sores		
Congenital Heart Defects		
COPD		
Cortico-Steroid Treatment		
Dizziness/Fainting		
Dry Mouth/Dry Eyes		
Emphysema		

PLEASE ADVISE US OF ANY CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS AT FUTURE APPOINTMENTS.

Patient's Signature: _____ Doctor's Signature: _____

APPOINTMENT/FINANCIAL POLICIES/RESPONSIBLE PARTY

Scheduling of Appointments

We make every attempt to arrange appointment times that are convenient: however, your flexibility and cooperation are greatly appreciated. Certain dental procedures will need to be scheduled at specific times during the day. Appointments are made in your best interest with your treatment plan in mind.

Haas Dental reserves time on the schedule for each patient. When appointments are cancelled, it impacts the overall quality of service we are able to provide. A pattern of cancellations/ no shows without 48 hours' notice may result in termination from the practice. A fee of $50 may be applied. To maintain the utmost service and care, we appreciate a **48-hour notice when cancelling appointments.** Patients arriving late for their appointment may be rescheduled as a courtesy to our other scheduled patients.

To reserve an appointment time for treatment of $1000 or more, *or* for appointments that are 90 minutes or longer, a ***deposit of 50% of your out of pocket amount,*** may be required. If an appointment is cancelled or rescheduled within the 48 hour period the deposit will be non-refundable.

Payment for Services

Payment is due at the time services are rendered. Any balance that is left unpaid for 30 days will be subject to interest charges. Any unpaid amount for 60 days may be referred to a collection company. A **$20** charge for each returned check will apply. For your convenience, we accept the following forms of payment: Cash, Check, Credit Card and Care Credit.

In the situation of divorced or separated parents, the responsible party on the account is responsible for costs incurred during a child's dental treatment. We cannot send statements to other people. Haas Dental Associates will not become involved with or responsible for employer sponsored tax deferred flexible benefits programs. We will be happy to provide necessary documentation for such benefits upon request.

Dental Benefit Plans/Insurance

As a courtesy we will bill your insurance company. Insurance companies are not financially responsible for treatment received. Benefits estimated are not a guarantee of payment. When an insurance company is billed and has not responded within 60 days, the amount billed is the insured's responsibility. It is your responsibility to fully understand your insurance benefits and to pay all balances remaining after insurance has considered the claim, or if you're insurance denies payment. **I understand that I am responsible for payment for services rendered, regardless of estimated insurance benefits.**

Authorizations

I understand that the information I have given today is correct to the best of my knowledge. I authorize Haas Dental Associates to perform dental services that they deem necessary for myself or my child. I understand that the expected results of said treatment cannot always be guaranteed. I understand that during the course of treatment, certain unforeseen conditions may be revealed that may necessitate extension or change from any previous treatment plans, and that such conditions may result in additional fees.

I have read the above and agree to the financial and scheduling terms.

I authorize the release of information necessary to process my benefit claims and authorize payment directly to Haas Dental Associates otherwise payable to me.

I hereby acknowledge that a copy of Haas Dental Associates' **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I hereby acknowledge that a copy of Haas Dental Associates **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

I authorize release of any information relating to insurance claims submitted on my behalf of my dependents. I hereby authorize payment of the dental benefits otherwise payable to me, to Haas Dental Associates.

We thank you for your cooperation and hope that any questions or concerns will be brought to our attention immediately so that we may act promptly in order to assure that your interaction with us is as pleasant as possible.

I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT.

Print Name of Responsible Party: _____ SS#: _____ DOB: _____

Address: _____ Date: _____

Signature of Responsible Party: _____ Date: _____ Patient's Name: _____

HAASDENTAL
ASSOCIATES

Informed Consent: Tooth Colored Composite Fillings

What is a composite resin (tooth colored) filling?

A composite resin is a tooth-colored plastic mixture filled with silicon dioxide. First introduced in the 1960's, dental composites were confined to the front teeth because they were not strong enough to withstand the pressure generated by the back teeth. Since then, composites have been significantly improved, and can be successfully placed in the back teeth as well. Studies have now shown that composites have strength, durability, and longevity comparable to silver fillings. Esthetics are far superior over silver fillings, and the dentist can blend shades to create a color nearly identical to that of the actual tooth. Composites also bond to the tooth to support the remaining tooth structure, which helps to prevent breakage and insulate the tooth from excessive temperature changes.

Our office only places composite resin (tooth colored) fillings. Please note that most dental insurance plans do not cover the entire cost of the composite fillings. This may result with the patient responsible for paying a modest balance. If you have any questions regarding your individual insurance coverage we recommend you review you insurance policy book prior to your appointment, or call your insurance company.

Informed Consent: New Patient Initial Examination

Radiographic (x-ray) policy

Please be advised that all new patients will have a full set of radiographs (x-rays) consisting of 18 individual x-rays or a panoramic radiograph (x-ray that goes around the head), and several individual x-rays for an adult. These x-rays are an integral part of our examination and evaluation of your teeth and surrounding bone. If you have had these x-rays taken recently at a previous dental office, it is your responsibility to either bring a copy of them with you to your examination, or have them sent to our office prior to your visit. For a pediatric patient, we will need any x-rays taken at a previous office. Without these pre-existing x-rays we will be unable to properly diagnose any dental or periodontal (gum/bone) problems you may have. If necessary, we can take new x-rays here, but please be aware that if you have dental insurance and have recently had x-rays taken, they will likely not cover new ones.

I certify that I have read the above information regarding composite resin tooth colored fillings, and recognize that if my insurance does not pay for tooth colored restorations, I am responsible for the balance. I certify that I have also read and understand the information regarding dental x-rays and new patient exam.

Signature: _____ Date: _____

Patient Name: _____

SPECIAL CONSENT AND RELEASE FOR TREATMENT

I hereby authorize the doctors of Haas Dental Associates, and such assistants and associates as may be designated, to perform dental treatment and any other related procedures or forms of treatment, including appropriate anesthesia or analgesia they may deem necessary.

I consent to dental examination, x-rays, consultation and treatment by Haas Dental Associates.

I authorize Haas Dental Associates to perform dental services that they deem necessary for myself or my child. I understand that the expected results of said treatment cannot always be guaranteed. I understand that during the course of treatment, certain unforeseen conditions may be revealed that may necessitate extension or change from any previous treatment plans, and that such conditions may result in additional fees.

The following has been discussed to my satisfaction:
1. The nature and character of the proposed treatment/procedure.
2. The anticipated results of the proposed treatment/procedure.
3. The recognized alternative forms of treatment/procedure.
4. The recognized serious possible risks and complications of the treatment/procedure, including non-treatment.
5. The anticipated date and time of the proposed treatment/procedure.

Haas Dental Associates have offered to answer all inquiries concerning the proposed treatment/procedure. I understand that I am free to withhold or withdraw consent to the proposed treatment/procedure at any time.

I have been informed of complications and risks involved in procedures to be performed and acknowledge that my questions regarding said risks/complications have been answered to my satisfaction.

I understand that no treatment will be performed until this consent has been executed and that it will be permanently filed in my dental record.

Signature: _____ Date: _____

Patient Name: _____

HAAS DENTAL ASSOCIATES

Disclosure and Authorization Form

Purpose:

For you to authorize the disclosure of your personal information, which may include health information, to persons or organizations outside of Haas Dental Associates. Your privacy is protected by state and federal privacy laws. As such, we need your explicit permission to make the requested disclosure. Please complete each section of this form.

Your Name and Identification Information:

Name: _____ DOB: _____ _____

Address: _____

City: _____ State: _____ Zip Code: _____ _____ _____

Telephone: ( ) _____ Last 4 Digits of SS#: _____ _____

To whom are we authorized to disclose your personal information?

Please state the names of the individuals or organizations, including contact information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Expiration Date or Event:

This authorization will remain in effect until you notify us, in writing, that you would like to revoke this authorization.

Right to Revoke:

You have the right to revoke this authorization at any time. You may revoke this authorization by giving written notice to Haas Dental Associates. Any disclosures of your person information, which we may have made under this authorization prior to revocation, will not be affected since they were made while this authorization was still in effect.

Further Disclosure:

Once we disclose your personal information, including health information, to the above persons or organizations, the information may no longer be protected under state or federal privacy laws. We cannot control what these persons or organizations do with your information.

Signature:

Having had full opportunity to read and consider the contents of this authorization, including my rights and the risks of further disclosure as described above, I authorize Haas Dental Associates to disclose my personal information, including health information, to the persons or organizations I have identified above. I understand that Haas Dental Associates will disclose only that information which is necessary to accomplish the stated purpose of the authorization. The information disclosed will be limited to the minimum necessary. I understand that I am under no obligation to sign this authorization. I also understand that the services and benefits provided to me by or through Haas Dental Associates will not be affected whether or not I sign this form.

Signature: _____ Date: _____

To revoke this authorization, please contact:

Name: _____ Date: _____

Take our….

SMILE ASSESSMENT

YES	NO	
€	€	**Are you happy with the appearance of your teeth?**
€	€	**Do you have unsightly crowns or fillings?**
€	€	**Are your teeth sensitive to hot or cold?**
€	€	**Do you feel that your teeth are too long or too short?**
€	€	**Do you like the color of your teeth?**
€	€	**Are you interested in replacing missing teeth?**
€	€	**Are you familiar with the benefits of dental implants?**
€	€	**Are your gums receding?**

What is holding you back from your perfect smile?

YES	NO	
€	€	**Fear**
€	€	**Time**
€	€	**Cost**
€	€	**Other** _____