



health • beauty • comfort • longevity

**S. MICHAEL LODEN, DMD**

• General & Restorative Dentistry •

**Welcome**

***On behalf of Dr. S. Michael Loden and our dental team, we are pleased to welcome you to our practice. Please take a few minutes to provide us with the following information.***

***All information will be kept confidential.***

**Patient Information**

Patient's Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
Emergency Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Is the patient a student? ☐ Full Time ☐ Part Time

**Responsible Party Information**

Person responsible for Account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work or Cell #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
Have you or any member of your family been a patient at this office before? ☐ Yes ☐ No  
If YES, please give us their name: \_\_\_\_\_

**Primary Dental Insurance Information**

Insured's Name: \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_  
Group or Policy #: \_\_\_\_\_  
Union/Group Name: \_\_\_\_\_  
Local #: \_\_\_\_\_ Date Employed: \_\_\_\_\_

**Secondary Dental Insurance Information**

Insured's Name: \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_  
Group or Policy #: \_\_\_\_\_  
Union/Group Name: \_\_\_\_\_  
Local #: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Who may we thank for recommending our office to you? \_\_\_\_\_

Otherwise, how did you learn about our practice?

☐ Internet ☐ Office Website ☐ Facebook ☐ Yellow Pages Other: \_\_\_\_\_

# Dental History

What is the primary reason for your visit today? \_\_\_\_\_  
Are you aware of any dental problem? If so, please explain: \_\_\_\_\_  
Last Dental Visit: \_\_\_\_\_  
Name of your previous Dentist and Dental Office: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

Please share the following dates:

Your last dental examination and cleaning: \_\_\_\_\_

Your last complete series of x-rays: \_\_\_\_\_

Your last oral cancer screening: \_\_\_\_\_

Was there any dental treatment your last dentist recommended for you? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

If your dental treatment was not completed, what prevented you from receiving it?

\_\_\_\_\_ Time \_\_\_\_\_ Cost \_\_\_\_\_ Fear \_\_\_\_\_ Other: \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

Please check any of the following problems that apply to you:

_____ Sensitivity (to hot, cold, sweets)	_____ Bleeding, swollen or irritated gums
_____ Tooth discomfort when chewing	_____ Loose, chipped or shifting teeth
_____ Teeth or fillings breaking	_____ Missing teeth
_____ Jaw Joint pain	_____ Bad breath and / or bad taste in your mouth
_____ Grinding / Clenching teeth	_____ Dry mouth

Please indicate current / past dental treatments:

_____ Dentures / Partial Dentures	_____ Braces	_____ Dental Implants
_____ Treatment for TMJ	_____ Wear a night guard / Splint	
_____ Teeth extracted (adult teeth)	_____ Deep cleanings / Periodontal Treatment	

What is the most important thing about your dental visit today?

On a scale of 1-10, with 10 being the highest,

How important is your dental health to you?

How would you rate your current dental health?

**Please check any of the following that APPLIES TO THE PATIENT:**

_____ AIDS/HIV+	_____ Anemia	_____ Arthritis	_____ Artificial Joints
_____ Seasonal allergies	_____ Asthma	_____ Blood Disease	_____ Bruise easily
_____ Chemotherapy	_____ Diabetes	_____ Dizziness	_____ Drug addiction
_____ Excessive bleeding	_____ Fainting	_____ Glaucoma	_____ Heart Conditions
_____ Hepatitis A/B/C	_____ High Blood Pressure	_____ Low Blood Pressure	_____ Jaundice
_____ Mitral Valve Prolapse	_____ Anxiety / Depression	_____ Pacemaker	_____ Seizures
_____ Respiratory illness	_____ Rheumatic fever	_____ Rheumatism	_____ Osteoporosis
_____ Stroke	_____ Thyroid disease	_____ Phen-Fen (diet pills)	_____ Liver Disease
_____ Allergies to antibiotics	_____ Tuberculosis	_____ Kidney Disease	_____ Latex Allergy
_____ Artificial Heart Valve	_____ Emphysema	_____ Radiation	other medical conditions:
_____ Cancer	_____ Heart Murmur	_____ Stomach Problems	_____

Do you smoke or use chewing tobacco? \_\_\_\_\_ Yes \_\_\_\_\_ No How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ Yes \_\_\_\_\_ No How much? \_\_\_\_\_ How Often? \_\_\_\_\_

Women only: Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No # of Weeks: \_\_\_\_\_ Nursing? \_\_\_\_\_

What medical conditions are you currently being treated for? \_\_\_\_\_

Physician's Name and Office: \_\_\_\_\_ Phone#: \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Has any physician or previous dentist recommended that you take antibiotics prior to your dental appointment? \_\_\_\_\_

Please list any medications you are allergic to or have bad reactions to: \_\_\_\_\_

*To the best of my knowledge, I have answered every question completely and accurately.*

*It is my responsibility to inform Dr. S. Michael Loden of any changes in my health and or in my medications.*

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Reviewed by:** \_\_\_\_\_



## Notice of Privacy Practices Patient Consent Form

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 been informed by you of your Notice of Privacy Practice, containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 at the address below to obtain a current copy of the *Notice of Privacy 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

If you are not available, can we discuss your account with your spouse or anyone else? Yes or No

If so, please list their names and date of birth \_\_\_\_\_

\_\_\_\_\_



### **THREE IMPORTANT COMMITMENTS**

We have three important commitments in our practice that we feel are valuable to share with you. We have put them in writing because we live by them and ask that all of our patients live by them as well. We have experienced that these three commitments may require actions that differ from what you may be accustomed to in the past, however, we believe they are very necessary. We ask that you read this page thoroughly.

#### **1. Commitment To Treatment**

We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, and misunderstandings. Incomplete treatment leads to loss of teeth and further disease. This policy states that all accepted treatment plans should be completed, once they are started. Some treatment plans, because of their design, take longer to complete. However, to begin staged treatment, your commitment to both starting and completing treatment is necessary.

#### **2. Commitment To Appointment**

We reserve time for each patient in our practice. An appointment for you on our schedule is a commitment that we will be here to serve you and you will be present for that appointment. As a partner in your dental health, we value our appointment time with you. We request that you be present for all scheduled appointments. We do not appreciate cancellations or constant short notice changes. Our office policy in this regard is extremely firm. We believe in mutual respect for each other's time.

#### **3. Commitment To Financial Agreement**

We believe we have a responsibility to use our best professional care, skill, and judgement in planning for your dental treatment. The benefits of treatment and liabilities of neglect are always explained by Dr. Loden in your Review of Findings.

- All fees will be properly explained to you prior to treatment.
- Acceptance of your treatment indicates your commitment to honor your financial obligations associated with that treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_



### **Office Policies**

We are a team of health care professionals dedicated to improving the lives of our patients by establishing relationships based on trust, compassion, and commitment. Our goal is to become a partner with our patients to help them achieve and maintain optimum health, beauty, and comfort for a lifetime.

In order to provide this quality of dental care, we request all of our patients pay their estimated personal cost of treatment at the time of service. As a courtesy to our patients, we will file your dental insurance claims for treatment you receive. However, in the event the insurance company does not pay their estimated portion, the balance will become the patient's responsibility.

Please take the time to understand your insurance policy and benefits. The benefits you receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company. Our goal is to help you achieve and maintain optimal dental health. Our office will do everything possible to help you understand and make the most of your dental insurance benefits and provide you with an estimate before any treatment is initiated. Please understand that estimates given are estimates, and may change depending on the individual insurance plan coverage.

All estimates for dental services will be valid for 90 days from the date of signed treatment agreement.

### **Policies for X-rays & Photographic records:**

X-rays in conjunction with a clinical exam are necessary for a thorough and accurate diagnosis and dental treatment plan. Examination x-rays are generally taken once a year for adults and every six months for children. However the frequency at which x-rays are taken will be based upon individual dental need.

Dental models and photographs may be taken to document and analyze clinical treatment. These records may be used for educational and viewing purposes by the practice. At no time will the patient's identity be disclosed.

### **Appointment Policy:**

We pride ourselves in providing adequate time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 2 business days notice if you need to reschedule your appointment.

### **Patient Responsibility:**

Below is a composite view of the different ways you may take care of your financial responsibilities in our office:

- Payment is expected at the time of services are rendered. Acceptable forms of payment are: cash, Check, and/or a valid Credit Card.
- For our patients who need extended credit terms to achieve their oral health goals, we will assist in arrangements with Care Credit for those who are approved.
- A 1.5% interest fee will be charged to all accounts past due 30 days and 60 days. We will attempt to resolve past due balances through our text-to-pay system, regardless of opt-out text option. After 90 days, account will be turned over to our Professional Partners (preferred collection agency) and are subject to a 30% recovery fee.

**I have read and agree to the office policies stated above.**

\_\_\_\_\_  
Date: \_\_\_\_\_  
*Signature of patient, parent or guardian*

\_\_\_\_\_  
Date: \_\_\_\_\_  
*Signature of guarantor of payment / responsible party*