





HEALTH HISTORY

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

Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Please list all medical problems you are currently being treated for: \_\_\_\_\_

Please list all of your previous surgeries: \_\_\_\_\_

Please list any drug, food or latex allergies: \_\_\_\_\_

Please list your current medications: including aspirin or any other over the counter medications: \_\_\_\_\_

DO YOU HAVE, OR HAVE YOU EVER HAD....

- Yes/No checkboxes for various conditions: Chest pain, Heart attack, Irregular heart beat, Pacemaker/defibrillator, Heart murmur, Angioplasty/bypass, High blood pressure, Heart valve replacement, Asthma, Shortness of breath, Emphysema/COPD, Sleep apnea, Tuberculosis, Tobacco use, Diabetes, Liver disease, Kidney disease, Thyroid disease, Rheumatic fever, Immune system problems, Hepatitis/jaundice, Cancer, Chemotherapy, Radiation therapy, Bleeding/blood clot problems, Anesthetic problems, Epilepsy/seizures, Glaucoma/eye problems, Ulcers/gastric reflux, History of alcohol or drug abuse, Currently pregnant/nursing, Hip/knee/joint replacement, Blood thinners, Bone density medication, Require antibiotics prior to surgery

DENTAL HISTORY (PLEASE CHECK ALL THAT APPLY):

- Checkboxes for dental history: Routine care only, Gum disease, Orthodontics, Cancer, Jaw/tooth trauma, Mouth sores, TMJ problems, Dental implants, Jaw surgery, Dentures

Please list anything else about your medical or dental history we should know: \_\_\_\_\_

Signature-Patient/Guardian

Dr's initials

UPDATED: \_\_\_\_\_ DATE: \_\_\_\_\_

**Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can be of service to you as comfortable as possible.**

1. Please rate the following statements regarding what is most important to you in dental care so we can best serve you: (#1 being the most important)

- \_\_\_ Long-Term Preventative Care...I have healthy teeth and want to keep them that way.
- \_\_\_ Creating a Comprehensive Overall Dental Care Plan...I want to Invest in my Teeth and Appearance
- \_\_\_ Dental Care is budget driven. I will have to plan financially for any treatment beyond my immediate needs.
- \_\_\_ Other Goals: \_\_\_\_\_

2. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)

1    2    3    4    5    6    7    8    9    10

3. Are you concerned about: (please circle yes or no)

Replacing missing teeth	Yes	No	Straightness of your teeth or bite	Yes	No
Eliminating any cavities	Yes	No	Snoring at night	Yes	No
Gum disease	Yes	No	Color of your teeth	Yes	No
Bad breath	Yes	No	Appearance of your smile	Yes	No

4. Are you or anyone in your family interested in a **complimentary** orthodontic (Braces or Invisalign) consultation with our Orthodontist?    Yes    No

**We know dental care can be very stressful for most people. Please share your concerns and past experiences to help guide us in serving you and your family more effectively.**

5. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)

1    2    3    4    5    6    7    8    9    10

6. When we review your treatment plan with you, would you like to know (please check one):

- \_\_\_ I am a big picture type person, I prefer to review the plan looking at all the things that need to be done.
- \_\_\_ I am a detail oriented person, I prefer to approach each treatment step along the way

7. Please briefly describe any bad dental experiences you have had: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THANK YOU**



DENTAL INSURANCE POLICY

Panorama Dental proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

**Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.**

-----PATIENT ACKNOWLEDGMENT AND AUTHORIZATION-----

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Panorama Dental. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

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

APPOINTMENT DEPOSIT REQUIREMENT

**Panorama Dental requires a minimum \$50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of \$500.00 or more.** The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Panorama Dental requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

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

CANCELLATION POLICY

Panorama Dental makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 48 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge a cancellation fee of \$50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

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

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, \_\_\_\_\_, have had the opportunity to review Panorama Dental's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

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



### **Credit Card on File Policy**

Thank you for choosing Panorama Dental for your dental needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible.

To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, Panorama Dental will require all patients to keep an active credit card on file with us, effective June 1, 2020 we will bill your insurance company first and upon their determination of benefits, we will only charge your credit card if they inform us of any patient responsibility. Circumstances, when your card would be charged, include but are not limited to missed or canceled appointments without 24-hour notice, co-payments, deductible and coinsurance any non-covered services, and/or denial of services.

- Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing the amount of your total patient responsibility. You will typically receive the EOB before we do, so if you disagree with the patient responsibility balance owed, contact your insurance carrier immediately.
- When we receive the EOB, we notify you if you owe any remaining balance. We will charge your credit card 7 days after that notification.

If the credit card we have on file for you changes, please notify the office IMMEDIATELY by phone or email. We know credit card information changes frequently, including when a credit card expires. That is quite understandable. If we run your credit card and it is denied for any reason, we will contact you at the phone number you provided to identify a new payment method.

We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you were in our office.

If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the same card in a timely manner. We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave an HSA (Health Savings Account), or Flex Plan Card on File.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

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