**Patient Information**

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

 Last First MI

 Male Female Married Single Child Other e-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext:\_\_\_\_\_\_ (Cell)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Apartment #

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip Code

**Responsible Party Information**

\*The parent or guardian of the child that **signs the paperwork** is the Responsible Party or Guarantor of financial account. This may be different than the provider of insurance.\*

Name:

 Male Female Married Single Child Other

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext:\_\_\_\_\_\_ (Cell)

Address:

 Street Apartment #

 City State Zip Code

## Insurance Information

# Primary

Name of Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is subscriber a patient? Yes No

 Last First MI

Subscriber’s Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

Subscriber’s Address:

 Street City State Zip Code

Subscriber’s Employer Name:

 Address:

 Street City State Zip Code

 Patient's relationship to subscriber: Self Spouse Child Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name and Address:

**Secondary**

Name of Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is subscriber a patient? Yes No

 Last First MI

Subscriber’s Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

Subscriber’s Address:

 Street City State Zip Code

Subscriber’s Employer Name:

 Address:

 Street City State Zip Code

 Patient's relationship to subscriber: Self Spouse Child Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name and Address:

**Referral Information**

Whom may we thank for referring you to our practice?

**Health Information**

• Have you ever had any complications following dental treatment? Yes No

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Are you allergic to any medications or substances? Yes No

 If yes, please check any boxes that apply:

 Aspirin Penicillin Codeine Acrylic Metal/Nickle Latex Other:

• Women (please check all that apply)

 Pregnant/trying to get pregnant Nursing Taking oral contraceptives

• Are you currently taking any medications, vitamins, herbs, pills, or drugs? Yes No

 If yes, please list:

• Are you currently under the care of a physician? Yes No

 If yes, please explain reason:

• Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Do you have any health problems that need further clarification? Yes No

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had/taken any of the following? Please check those that apply:**

|  |
| --- |
|  Heart Disease/Surgery |
|  Heart Murmur or Defect |
|  Irregular Heart Beat  |
|  Angina/Chest Pain |
|  Heart Attack/Failure |
|  Congenital Heart Disorder |
|  Mitral Valve Prolapse |
|  Rheumatic Fever |
|  Artificial Heart Valve |
|  Heart Pace Maker |
|  Pulmonary Shunt |
|  High Blood Pressure |
|  Swelling of Limbs |
|  Lung Disease |
|  Breathing Problems |
|  Shortness of Breath |
|  Frequent Cough |
|  Hay Fever |
|  Sinus Trouble |
|  Asthma |
|  Bloody Sputum |
|  Emphysema |
|  Tuberculosis |
|  Cancer |
|  Liver Disease |
|  Hepatitis A (Infectious) |
|  Hepatitis B and C |
|  Protease Inhibitor |
|  Night Sweats |
|  Yellow Jaundice |
|  Kidney Problems |
|  Renal Dialysis |
|  Thyroid Disease |
|  Parathyroid Disease |
|  Arthritis/Gout |
|  Rheumatism |
|  Herpes |
|  Stroke |
|  Convulsions |
|  Epilepsy or Seizures |
|  Fainting or Dizziness |
|  Glaucoma |
|  Tumors or Growths |

 Nervousness



|  |
| --- |
|  Low Blood Pressure Bacterial Endocarditis Bruise Easily  Blood Disease Anemia Coronary Stent Excessive Bleeding Blood Thinners Hemophilia Methemoglobinemia Leukemia Recent Blood Transfusion |
|  Sickle Cell Disease |
|  X-Ray Treatments (Radiation) Chemotherapy Osteoporosis Bisphosphonates (Bone Loss) Osteonecrosis of Jaw Intestinal Disease Ulcers Recent Weight Loss Frequent Diarrhea Diabetes Excessive Thirst Hypoglycemia |
|  Intestinal Disease |
|  Cortisone Medicine Artificial Joint Sexually Transmitted Disease AIDS HIV Positive Genital Herpes Drug Addiction/Alcoholism Tattoos/Body Piercing Cold Sores Fever Blisters Psychiatric Care |
|  Alzheimer’s Disease Allergies (Medicines) Allergies (Pollen/Dust) Hives or Rash Pre-Medication Fen-phen OTHER:   |
| (For office use only) |

BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

P: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

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

 Printed name of patient

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of patient, parent or guardian

**Dental Information**

• Do you have a specific dental problem? Yes No

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Do you have dental examinations on a routine basis? Yes No

 If yes, when was your last visit?:

• How often do you brush? Floss?

• Do you like your smile? Yes No

 If no, please list:

• Have your past experiences in a dental office always been positive? Yes No

 If no, please explain:

• Do you wish to talk to the dentist privately about any problem? Yes No

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had any of the following dental concerns? Please check those that apply:**

|  |
| --- |
|  Food catches between teeth |
|  Loose teeth |
|  Clicking/popping of jaw joints  |
|  Discomfort in the jaw joints |
|  Grind teeth |
|  Smoke tobacco |
|  Chew tobacco |
|  Bleeding gums |
|  Sore gums |

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my dental health, I will inform the doctors at the next appointment without fail.

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

 Signature of patient, parent or guardian

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

 Signature of Doctor

# Consents

Welcome to Downtown Dental! Please take a few minutes to review the following financial agreement and Receipt of Notice of Privacy Practices. We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this office for our patients and the community. ***Please initial each paragraph.***

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I have received and reviewed a copy of our dental practice’s privacy, security and breach notification policies and procedures. I understand that I should ask our dental practice’s Privacy Official if I have any questions about these policies and procedures.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Charges for our dental services at our office are due and payable at the time the services are rendered. We accept cash, check, Visa, MasterCard, Discover, and Care Credit. Copays and deductible estimates are due at the time of service and, as a courtesy; we will submit the covered charges to your insurance and allow 45 days for payment. At that time you will be required to pay the full charges and settle with your insurance company. **Please understand that your insurance is an agreement between you and your insurance company to pay a certain amount for your care. Our bill for services is an agreement between you and our office.** You are responsible for the payment of your bill regardless of the status of your insurance claim. If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our Patient Care Coordinator. This will avoid misunderstanding and enable you to keep your account in good standing. Accounts 90 days past due are referred to a collection agency or small claims court, unless prior arrangements have been made with our office. Also we will no longer be able to provide for your (dependent) care.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_ All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‘I request that payment of authorized dental or any other applicable health insurance benefits be made either to me or on my behalf to Downtown Dental for any services provided to my dependent(s). I authorize any holder of dental/medical information about my dependent(s) to release any information needed to determine benefits or benefits payable for related services to the applicable insurance agencies.’

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In order to be respectful of the doctor and all patients’ time, kindly give sufficient notice if you are unable to keep your appointment. If appointments are rescheduled without **48 hours notice**, you may be charged a fee. If you miss three appointments without prior timely notice, you may be discharged from the practice. If more than **10 minutes late**, we may ask you to reschedule for another time.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I authorize the following options to contact me for patient notifications, appointment reminders and any other office communications.

 Phone Call/Voice Message \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Text Message \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_I consent to the use of my radiographs, dental records and photos for scientific publication or teaching, providing my name remains anonymous.

If you should have any question regarding the above policies, please feel free to discuss it with our Patient Care Coordinator.

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

Signature of patient, parent or guardian

DOWNTOWN DENTAL SERVICES

Michael J. Krump DDS, PC

623 Quincy Street

Rapid City, SD 57701

605-342-4882

605-342-4848 Fax

Email: office@downtowndentalrc.com

Request for dental records and x-rays

Previous Dentist Name:

Dentist Phone Number:

Patient Names:

If minor parents name:

Date of Birth:

Patient Address at the time:

Telephone Number:

Patients Signature:

Please email any updated records or x-rays to the above address. If you need any additional information, please do not hesitate to call. Thank you.