IRONWOOD
dental care

Ironwood Dental Care P.C.

Financial Policy

We have written this information guide to enable our staff to attend to your dental health needs on a more personal level; we hope it will make it easier to understand our office policy regarding your financial obligation. We will try and bill you at the appropriate time and file your insurance claims for you. My staff and I will strive to have open communications on all financial matters. If you have any questions or problems, please bring them to our attention. We are here to help.

1: Patient care is our primary goal.
2: For patients with insurance, as courtesy, we will file your insurance claim for you. You will be expected to pay your deductibles and co-insurance at each visit, and any portion not covered by your insurance. Please understand that what we collect are only **estimates** and you are ultimately responsible for any and all of the cost of your dental care. After you dental claim is paid, you will be billed for the remaining balance.
3: If, after 90 days your insurance company has not paid on your claim, you will be billed for the entire balance.
4: Our office reserves appointment times especially for you when you schedule them. If you are unable to make a scheduled appointment with our office, please notify us at least 24 hours prior to your appointment, so that we may schedule another patient at that time. If there is less than 24 hour cancellation notification, there will be a $50.00 missed appointment charge.
5: We suggest that you know the limitation of your insurance. If you are limited, by your insurance plan, to a certain number of visits per year or have contractual waiting periods; please keep track of this information. You will be held responsible for payment.
6: We accept MasterCard, VISA, cash, check, and money orders. Any check returned from the bank will be subject to a $45.00 charge and cash will be required for future visits.
7: All first time visits and emergencies; Full payment is due at the time of service.
8: Please ask our office staff if you have any questions.

I have read, understand, and accept that I am responsible for any and all fees that are incurred by me at Ironwood Dental Care, P.C.

_____ _____
Patient or Guardian Signature Date

_____
Printed Name

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Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other. (Please Specify)_____

  _____.

Welcome to Ironwood Dental Care. Please fill out this form completely and print clearly. If you have any questions we will be glad to help you.

PATIENT INFORMATION:

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Sex: M ☐ F ☐ Age: _____ Birth date: _____ Marital Status: Single ☐ Married ☐ Widowed ☐

Patient SSN: _____-_____-_____ **Email Address**: _____

How would you like us to confirm your appointments? (Multiple is okay) Home ☐ Work ☐ Cell ☐ Email ☐

Home Number: _____ Cell Number: _____ Work Number: _____

Occupation: _____ Employer: _____

Employer Address: _____ Drivers License #:_____ State: _____

If the patient is a student: School Name: _____ Grade: _____

How did you hear of the office (passed by, yellow pages, internet, and referral) _____?

Emergency Contact: _____ Phone Number: _____

ACCOUNT INFORMATION:

Person responsible for this account: _____ Relationship: _____

SSN: _____-_____-_____ Birth date: _____ Drivers License #:_____ State: _____

Home Number: _____ Cell Number: _____ Work Number: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

INSURANCE:

Name of Insured (person who holds the insurance):_____

SSN: _____-_____-_____ DOB: _____

Relationship to patient: _____ Insurance Co.:_____ Grp#:_____

Is patient covered by additional dental insurance? Yes ☐ No ☐

Names: _____ SSN: _____-_____-_____ DOB: _____

Relationship to patient: _____ Insurance Co.:_____ Grp#:_____

Medical Insurance Company: _____ SSN: _____-_____-_____ Grp#:_____

Name of Insured: _____ DOB: _____

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO DR. STANLEY ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

ASSIGNMENT AND RELEASE:

I UNDERSTAND THAT IF MY ACCOUNT BECOMES DELINQUENT, AND THIS OFFICE TURNS MY ACCOUNT OVER TO A COLLECTION AGENCY, I WILL BE RESPONSIBLE FOR ANY FEES THAT ARE INCURRED IN THE PROCESS, AS WELL AS THE BALANCE OWED.

_____

Responsible Party Signature Relationship Date

DENTAL HISTORY

Name:_____ DOB:_____

Check if you have or have had any of the following:

	Y	N		Y	N		Y	N
Bad Breath	☐	☐	Chewing ice	☐	☐	Fever blisters in mouth or on lips	☐	☐
Grinding/Clenching teeth	☐	☐	Pain around ear or jaw	☐	☐	Cold sores or growths in mouth	☐	☐
Bleeding or sore gums	☐	☐	Chewing on one side of mouth	☐	☐	Problems with extractions or surgery	☐	☐
Dry Mouth	☐	☐	Food collection between teeth	☐	☐	Excessive bleeding from an extraction	☐	☐
Mouth Breathing	☐	☐	Mouth pain while brushing	☐	☐	Orthodontic Treatment (Braces)	☐	☐
Lip or Cheek biting	☐	☐	Loose teeth or fillings	☐	☐	Periodontal Treatment (Gum Surgery)	☐	☐
Fingernail biting	☐	☐	Clicking or popping of jaw	☐	☐	Dentures? Partial (U/L) Full (U/L)		

Sensitivity to: (circle) **COLD HEAT SWEETS** when biting? Where?_____

Reason for today's visit:_____

Former Dentist:_____. Date of last visit?_____

Date of last dental x-rays taken?_____. How many were taken/what type?_____

How often do you brush?_____. Floss?_____. Pain or bleeding after brushing/flossing?_____

Have you had a negative reaction to local anesthetic?_____. Any anxiety about your dental visit?_____

Any teeth giving you pain? (where)_____

Do you like your smile? Do you feel that it can be improved?

HEALTH HISTORY

Physician's Name:_____ Phone:_____ Date of Last Visit:_____

Check if you have, or have had any of the following:

	Y	N		Y	N		Y	N
AIDS/HIV	☐	☐	Hepatitis: Type_____	☐	☐	Skin Rash	☐	☐
Artificial Heart Valve	☐	☐	Narrow Angle Glaucoma	☐	☐	Special Diet	☐	☐
Diet Pills/ Phen-Fen	☐	☐	Chemotherapy/Radiation	☐	☐	Stroke	☐	☐
Murmur / Heart Problems	☐	☐	Circulatory Problems	☐	☐	Swelling of feet or ankles	☐	☐
Describe:_____	☐	☐	Cortisone Treatments	☐	☐	Swollen neck glands	☐	☐
Fosamax	☐	☐	Cough, persistent or bloody	☐	☐	Thyroid Problems	☐	☐
Congestive Heart Failure	☐	☐	Diabetes	☐	☐	Tonsillitis	☐	☐
High Blood Pressure	☐	☐	Epilepsy/ seizures	☐	☐	Tobacco use:	☐	☐
Mitral Valve Prolapse	☐	☐	Fainting or dizziness	☐	☐	Tuberculosis	☐	☐
Pacemaker	☐	☐	Glaucoma	☐	☐	Tumor/growth on head/neck	☐	☐
Rheumatic Fever	☐	☐	Headaches	☐	☐	Ulcer	☐	☐
Alcohol, drug abuse	☐	☐	Herpes	☐	☐	Respiratory Disease (lung)	☐	☐
Anemia	☐	☐	Kidney Disease	☐	☐	Venereal Disease	☐	☐
Angina	☐	☐	Liver Disease	☐	☐	Wear Contact lenses	☐	☐
Arthritis, Rheumatism	☐	☐	Low Blood Pressure	☐	☐	Weight change- unexplained	☐	☐
Artificial Joints (knee, hip)	☐	☐	Cancer	☐	☐	Women:	☐	☐
Asthma	☐	☐	MAOI Drugs	☐	☐	Are you pregnant?	☐	☐
Back Problems	☐	☐	Scarlet Fever	☐	☐	Are you nursing?	☐	☐
Blood Disease	☐	☐	Shortness of Breath	☐	☐	Using Birth Control Pills?	☐	☐
Blood Transfusion	☐	☐	Sinus Trouble	☐	☐	Other: _____	☐	☐

Tobacco use: Amount? _____ How long have you used tobacco? _____

Is there any condition not listed that you have?_____

MEDICATIONS:

Check here if you are not taking any medications ☐

Below, please list any medications you are currently taking:
(Including vitamins and herbal medicines)

_____
_____
_____
_____
_____
_____
_____

Pharmacy: _____Phone:_____

ALLERGIES:

Check here if you have no known allergies ☐

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic (Novocain)
- ☐ Penicillin/Amoxicillin
- ☐ Sulfa
- ☐ Valium
- ☐ Other: (Food or Medicine)

_____
_ _____
__ _____
___

CONSENT:

The information on this questionnaire is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in medical status, I will inform the dentist. The undersigned hereby authorizes the doctor, or doctor's staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Refusal of diagnostic aids at any time will release the doctor of responsibility for early diagnosis. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated.

Patient or Responsible Party (Parent/Guardian of minor) : _____ Date: _____

Doctor's Signature: _____ Date: _____