Dr. Tina Nichols DDS

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Divorced ☐ Child ☐ Widow

Preferred Pronouns: _____(optional)

Is anyone in your immediate family a current patient? ☐Yes ☐No Name: _____

Social Security # _____ Driver's License # _____ Birth Date_____

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

Email Address: _____

Preferred method of contact:☐ Text Message ☐ E-Mail ☐ Phone Call

Address: _____
Street Apartment #

_____
City Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Patient ☐ Relative ☐Friend ☐Dental Office

☐ Yellow Pages ☐ Internet ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice? _____

Do you love your current smile? ☐Yes ☐No If not, what would you change?_____

_____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit? _____

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

☐ AIDS/HIV	☐ Hay Fever	☐ Pregnant	Allergies: _____
☐ Anemia	☐ Head Injuries	Due Date:_____	_____
☐ Arthritis	☐ Heart Disease	☐ Radiation Treatment	_____
☐ Artificial Joints	☐ Heart Murmur	☐ Respiratory Problems	_____
☐ Asthma	☐ Hepatitis	☐ Rheumatic Fever	_____
☐ Blood Disease	☐ High Blood Pressure	☐ Rheumatism	_____
☐ Cancer	☐ Jaundice	☐ Sinus Problems	Current Medications: _____
☐ Diabetes	☐ Kidney Disease	☐ Stomach Problems	_____
☐ Dizziness	☐ Liver	☐ Stroke	_____
☐ Epilepsy	☐ Mental Disorders	☐ Tuberculosis	_____
☐ Excessive Bleeding	☐ Mitral Value Prolapse	☐ Tumors	_____
☐ Fainting	☐ Nervous Disorders	☐ Ulcers	_____
☐ Glaucoma	☐ Pace Maker	☐ Venereal Disease	_____
☐ Growths			

☐ Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

☐ Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:_____

☐ Are you now under the care of a physician? ☐Yes ☐No
If yes, please explain:_____

☐ Name of Physician: _____ Phone: _____

☐ Do you have any health problems that need further Clarification? ☐ Yes ☐ No
If yes, please explain: _____

Employment Information

Employer Name _____ Occupation _____

Address _____

Street City State Zip Code Phone

Insurance Information

Do you have dental insurance? Yes No

Sleep Apnea

Do you snore or have you been told your snore? Yes No

Have you been diagnosed with sleep apnea? Yes No

Do you wear a C-PAP? Yes No

Have you ever wore a C-PAP in the past? Have you been told to? Yes No

Have you had a sleep study or been told to get a sleep study? Yes No

Parent or Guardian Information

☐ Father ☐ Step-Father ☐ Guardian

_____ ____/____/____

Name Date of Birth

SSN _____ DL# _____

Employer _____

☐ Mother ☐ Step-Mother ☐ Guardian

_____ ____/____/____

Name Date of Birth

SSN _____ DL# _____

Employer _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimated listed for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

DR. TINA NICHOLS DDS POLICY & PROCEDURE ACKNOWLEDGEMENT OF RECEIPT OF HIPAA POLICIES AND PROCEDURES

*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 the front desk if I have any questions about these policies and procedures.

Name: _____

Signature: _____

Date: _____

I authorize Dr. Tina Nichols DDS office to discuss information pertaining to my account to the following individual(s)

_____

Name Phone Relationship

_____

Name Phone Relationship

<u>*Your account includes but is not limited to: balances, credits, treatment records, scheduled appointments and missed appointments*</u>

48 HOUR NOTICE POLICY

It is very important that we receive notice of a change in plans at least 48 hours in advance. This gives us the chance to schedule another patient in your place. If we do not have sufficient notice regarding a schedule change, we will be unable to care for another patient in need of our services.

I am sure that you understand why we must have policies along these lines. It is our policy to charge a $50.00 missed/cancelled appointment fee to any patient that cancels their appointment the day of the appointment.

I understand that by signing this agreement I am expected to adhere to the policies set forth within this notice.

_____

SIGN HERE **DATE**

DR. TINA NICHOLS DDS

FINANCIAL POLICY (for all patients)

Thank you for choosing our office as your dental care provider. The following describes our FINANCIAL POLICY. Our office is committed to providing you with the best possible care. **Your understanding of our policies is an essential element of your care and service.** If you have any questions regarding any aspect of our policies, please feel free to present your question to any of our team members.

Payment for services is due at the time services are rendered. We accept cash, debit, and for your convenience Visa, MasterCard, American Express, Discover and third party financing with Care Credit.

***Patients that have dental insurance we will be filling, will be expected to pay their full estimated portion and any deductible due at the time of service and patients that will be self-paying, are expected to pay the full amount due on the date of service.**

INSURANCE POLICY AND ASSIGNMENT OF BENEFITS

As a courtesy, we will file the necessary forms to see that you receive the full benefits of your coverage. Because your insurance policy is a contract between you, your employer, and the insurance company, **it is your responsibility to make sure our office has the most up to date and accurate insurance carrier information.** If the insurance company has not paid your claim within 45 days, the remaining balance will automatically become the patient's responsibility.
_____ (initial please)

Patient/Guardian Signature: _____

Printed Name: _____

Date: _____