Responsible Party

First Name _____ **Last Name** _____ **Middle Initial** _____

Birth Date _____ **Social Security Number** _____ **Marital Status** _____

Address_____

City, State, Zip Code _____

Phone Home _____**Cell** _____ **Work** _____

Email Address _____

Patient (if same as responsible party you may leave blank)

First Name _____ **Last Name** _____ **Middle Initial** _____

Birth Date _____**Social Security Number** _____ **Marital Status** _____

Address_____

City, State, Zip Code _____

Phone Home _____**Cell** _____ **Work** _____

Email Address_____

How Did you Hear about Us! _____

(If you heard from one of our patients let us know who!)

Primary Insurance Information

Name of Insured _____ **Relationship to insured** _____

Insured/ Subscriber SSN/ID#_____ **Insured DOB**_____

Employer_____

Ins Co _____ **Ins Co Phone #**_____

Ins Co Address _____

Secondary Insurance Information

Name of Insured _____ **Relationship to insured** _____

Insured/ Subscriber SSN/ID#_____ **Insured DOB**_____

Employer_____

Ins Co _____ **Ins Co Phone #**_____

Ins Co Address _____

Patient/ Guardian Signature /Date_____

Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

(Circle Yes or No)

Are you under a physician's care now? Yes No If Yes _____
Have you ever been hospitalized or had a major operation? Yes No If Yes _____
Have you ever had a serious head or neck injury? Yes No If Yes _____
Are you taking any medications, pills or drugs? Yes No If Yes _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No If Yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other Yes No If Yes _____
Medications containing bisphosphonates?
Are you on a special diet? Yes No
Do you use tobacco? Yes No If Yes _____
Do you use cannabis? Yes No If Yes _____

Women: Are you
Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Taking Birth Control? Yes No

Are you allergic to any of the following? (circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other ? IF Yes _____

Do You, or have you had, any of the following ? (Circle Yes or No)

AIDS/HIV	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B/C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives/Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed above ? yes or no If Yes _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

_____ **Date:**_____

Consent for Treatment

I, _____, consent to be a patient at Victory Dental Group and agree to a radiographic and clinical examination. I also understand and consent to the following:

1.During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2.I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3.No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4.I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

5.My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6.I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Office Financial Policy

1. Victory Dental Group will process dental claims as a courtesy to our patients. As a patient you may be directly responsible for the costs associated with treatment if payment is not received by your insurance company within 45 days of the claim being received by your insurance company.

2.If you don't not have insurance, or you carry an insurance that does not reimburse our office, payment is due at time services are rendered.

3.We accept all major credit cards, cash, checks, and Care Credit.

4.I agree to pay a $40 fee on all returned or cancelled checks.

5. I understand that there is a no call/no show cancellation fee for all appointments. The fee is $50 per scheduled hour. No fee will be charged if appointment is cancelled within 24 hours of the appointment time.

6. I will be financially responsible for all outstanding charges. I agree to pay a minimum monthly billing charge of $5.00 or interest at the rate of 1.75% per month (whichever is greater) on any balance not paid within 30 days of the date of service. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 33% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee

I authorize and request my insurance company to pay insurance benefits directly to the Victory Dental group. I understand that my dental insurance carrier may pay less than the actual bill for services and that I will be responsible for payment of all services rendered on my behalf. To the best of my knowledge, the questions on this form have been correctly answered. I understand that providing incorrect information can be dangerous to my health. It is my responsible to inform the dental office of any changes in medical status.

_____ _____

Patient or Guardian Name **Date**

Medical Information Release Form

(HIPPA Release Form)

Name: _____ DOB_____

Release of Information

☐ **I Authorize the release of information the diagnosis, records, examinations rendered to me and claims information. This information may be released to:**

☐ **Spouse _____**

☐ **Child(ren) _____**

☐ **Other _____**

☐ **Information not be released to anyone.**

This release of information will remain in effect until terminated by me in writing.

TCPA Acknowledgment

I authorize this office, its agents and assignees to contact me by telephone, text, SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.

Messages

Please call home _____ work _____ cell _____

If Unable to reach me:

☐ **You may leave a detailed message**

☐ **Please leave a message asking me to return your call**

☐ **Other _____**

The Health Insurance Portability & Accountability Act of 1966 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally be kept confidential.

Signed _____ Date _____

Victory Dental Group

24 hour Appointment Cancelation Policy Consent form

If you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. If you miss, cancel or reschedule an appointment with less than 24 hour notice our cancelation policy is as follows:

1st instance: We understand that life happens and schedule conflicts may arise unexpectedly. The first instance of a missed, called, or rescheduled appointment within 24 hours of your scheduled appointment time will not be counted against you and no fee will be charged.

2nd instance: We will charge $50.00 per hour of appointment time scheduled which must be paid prior to scheduling another appointment. If your insurance does not allow this charge, you will have to wait 60 days to reschedule your appointment.

3rd instance: The third instance will result in a dismissal from our practice.

Severe weather is excluded from the cancellation policy.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Victory Dental Group as describe above. **Signing of the consent is acceptance of all terms as they are written. No amendments or modifications will be granted**.

_____ _____

Patient Signature or minor Name Date

_____ _____

Guardian Name Date