WELCOME TO TOPSHAM DENTAL ARTS!
Patient Information (please print)

Legal Name:_____ Preferred Name:_____

Date of Birth: _____/_____/_____ Social Security Number: _____-___-_____ (only needed if filing insurance claims)

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

May we leave detailed messages on any of your answering machines/voicemails? Yes No

Preferred Pharmacy: _____ Telephone: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone : _____

Employer: _____

Whom may we thank for referring you to us? _____

Person Financially Responsible for Account (if other than patient)

Name: _____ Relationship to Patient: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Financial responsibility for care of a minor child outlined in legal agreements is independent of our office policy. The parent/guardian who brings the child to the office is expected to pay at the time services are rendered.

APPOINTMENT RESERVATION AGREEMENT

We strive to create a schedule that most efficiently provides for the dental needs of all our patients. Our goal is to see you on the date and time we have mutually agreed upon. This dedicated time is reserved specifically for you.

Please arrive on time for your scheduled appointments. Late arrivals may be worked into the schedule only if time allows or a re-scheduled time may be necessary.

If you cannot make your appointment, we request that you provide our office with a **2 business day notice**.

If you fail to provide a 2 business day notice, 2 or more times within 24 months, we may ask you for a non-refundable deposit to reserve appointment time. The non-refundable deposit will be applied to your treatment when you keep the appointment.

Patient or Parent/Legal Guardian Signature: _____ Date: _____/_____/_____

Topsham Dental Arts, LLC
Topsham Dental Arts Medical History

Patient Name: Birth Date: Date Created:

Although dental clinicians treat the area in and around your mouth, your mouth is a part of your entire body. Health problems and medications have an important relationship in your dental care. Thank you for answering the following questions completely.

Are you under a physician's care for more than an annual physical?	O Yes O No	If yes	
Have you ever had a serious head or neck injury?	O Yes O No	If yes	
Have you ever been hospitalized and/or had a major operation?	O Yes O No	If yes	
Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No	If yes	
Are you vegan, gluten free or on a special diet?	O Yes O No	If yes	
Do you currently use tobacco?	O Yes O No	If yes	
Have you formerly used tobacco?	O Yes O No	If yes	
Have you ever been advised to take antibiotics prior to dental treatment?	O Yes O No	If yes	

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	o Yes o No	If yes	
Do you use controlled substances?	o Yes o No	If yes	

Please list all medications and supplements you take.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

OVER

Do you have or do you have a history of any of these conditions?

Angina	○Yes ○No	Diabetes	○Yes ○No	Artificial Joint	○Yes ○No	Drug Addiction	○Yes ○No
Chest Pain	○Yes ○No	Hypoglycemia	○Yes ○No	Arthritis	○Yes ○No	Psychiatric Care	○Yes ○No
Congenital Heart Disorder	○Yes ○No	Anemia	○Yes ○No	Osteoporosis	○Yes ○No	Frequent Headaches	○Yes ○No
Fainting/Dizziness	○Yes ○No	Blood Transfusion	○Yes ○No	Rheumatism	○Yes ○No	Sinus Trouble	○Yes ○No
Cardiac Pace Maker	○Yes ○No	Bruise Easily	○Yes ○No	Kidney Disease	○Yes ○No	Asthma	○Yes ○No
Heart Attack/Failure	○Yes ○No	Excessive Bleeding	○Yes ○No	Liver Disease	○Yes ○No	Breathing Problems	○Yes ○No
Heart Murmur	○Yes ○No	Hemophilia	○Yes ○No	Renal Dialysis	○Yes ○No	Emphysema	○Yes ○No
Heart Trouble/Disease	○Yes ○No	Leukemia	○Yes ○No	Thyroid Disease	○Yes ○No	Lung Disease	○Yes ○No
Irregular Heartbeat	○Yes ○No	Cancer	○Yes ○No	Cold Sores	○Yes ○No	Epilepsy or Seizures	○Yes ○No
Heart Valve Replacement	○Yes ○No	Chemotherapy	○Yes ○No	Hepatitis A	○Yes ○No	Scarlet Fever	○Yes ○No
Low Blood Pressure	○Yes ○No	Radiation Treatment	○Yes ○No	Hepatitis B	○Yes ○No	Crohn's Disease	○Yes ○No
High Blood Pressure	○Yes ○No	Eating Disorder	○Yes ○No	Hepatitis C	○Yes ○No	Sleep Apnea	○Yes ○No
High Cholesterol	○Yes ○No	Acid Reflux	○Yes ○No	Tuberculosis	○Yes ○No	Snoring	○Yes ○No
Mitral Valve Prolapse	○Yes ○No	Stroke	○Yes ○No	HIV/AIDS Positive	○Yes ○No	Dental Anxiety	○Yes ○No
Rheumatic Fever	○Yes ○No	Gout	○Yes ○No				

Have you had an illness not listed above? ○ Yes ○ No If yes

Women: Are you…

☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing?

Additional Notes

I have done my best to answer these questions accurately. It is my responsibility to inform the dental clinicians of any changes in my medical status.

Signature of Patient, Parent or Guardian

Date:_____

TOPSHAM DENTAL ART
HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years.

There are rules about who may see or know your Protected Health Information (PHI). These restrictions do not impede the normal interchange of information necessary to provide you with dental care. HIPAA defines certain rights and protections for you as the patient. We balance these rights with our goal of providing you with quality, courteous professional care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

Our Policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories and health insurance payers as is necessary and appropriate for your care. Patient files are stored in file cabinets and password protected databases. In the normal course of providing care records may be left temporarily in administrative areas and treatment rooms. Your records are not available to persons other than office staff. You agree to these normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. As a courtesy, we remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or other means requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. You understand and agree to inspections of the office and review of documents that may include PHI by government agencies or insurance payers in normal performance of their duties.

4. You agree to bring any concerns regarding privacy to the attention of the office manager or the doctor.

5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

6. We agree to provide patients with access to their records in accordance with state and federal laws.

7. We may change, add, delete, or modify any of these provisions to better serve your needs or the needs of the practice.

8. You may request particular restrictions on the use of your PHI.

9. The following person(s) _____ have my permission to receive information about my PHI including, but not limited to diagnosis, treatment plans, account information, and have my approval to schedule appointments.

I, _____(print name), consent and acknowledge my agreement to the terms set forth in this HIPAA FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient or Parent/Legal Guardian Signature:_____ Date_____/____/____

TOPSHAM DENTAL ARTS (TDA)
Financial Information

Payment is expected at the time dental care is received. If you have dental insurance, payment means your *estimated* non-insurance portion. If you do not have insurance, payment means your fees for services received.

Payment Options: we accept cash, checks, and Visa, MC, American Express and Discover credit cards.

If a check is returned to us by the bank, a $35 "Returned Check" fee will be charged to your account.

Patients who have no dental insurance will receive a **10% courtesy** when paying in full, at time of service with **cash or check**.

Patients who have no dental insurance will receive a **5% courtesy** when paying in full, at time of service with a **debit or credit card**.

We offer the Topsham Dental Arts Oral Health Membership Plan for patients who do not have dental insurance.

Upon approval with Care Credit, we offer our patients a 6-month, interest-free term loan. Patients using Care Credit are not eligible for other courtesies because TDA is paying the finance charges to Care Credit on the patient's behalf.

If you have dental insurance, we are happy to assist you by filing claims. If there are issues with a claim that we cannot resolve, then the balance will become yours to pay.

Primary Dental Insurance Carrier

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Dental Insurance Company: _____ Telephone Number: _____

Policy #:_____ Group #:_____ Employer: _____

Secondary Dental Insurance Carrier

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Dental Insurance Company: _____ Telephone Number: _____

Policy #:_____ Group #:_____ Employer: _____

I authorize TDA to release information including the diagnosis and records of any treatment rendered to me or my dependents to the insurance company(s).

I understand that my dental insurance may pay less than the actual fee for services rendered and agree to be financially responsible for payment of all services provided to myself and my dependents.

I understand that if I do not provide ***accurate insurance information in a timely manner***, that it may forfeit payment by my insurance company(s) and I am financially responsible for all unpaid services.

Responsible Person Signature: _____ Date:_____/_____/_____
Print Name: _____

TOPSHAM DENTAL ARTS

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DENTAL RECORDS REQUEST FORM

This release is good for 90 days

Date: _____/_____/_____

Patient's Name: _____

Patient's Date of Birth: _____/_____/_____

□ I give Topsham Dental Arts permission to **release** copies of my dental records to

□ I give Topsham Dental Arts permission to **obtain** copies of my dental records from

Dental Office Name: _____

Address: _____

Phone: _____ Email: _____

Signature (Parent/Legal Guardian): _____

Print Name: _____