PerioWest™
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(952) 567-7457

Patient Information

Title First Name M.I. Last Name Date
I prefer to be called Email:
Address City State Zip
Home Phone Cell Phone Business Phone Ext.
Preferred Contact # Social Security # **Gender** ☐ Male ☐ Female
Date of Birth / / **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
How did you find out about us?
Other family members seen by us:

Emergency Contact

Title First Name M.I. Last Name Suffix
Relationship to Patient
Home Phone Cell Phone Business Phone Ext.

Responsible Party / Patient

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other:
Title First Name M.I. Last Name Suffix
Address City State Zip
Home Phone Business Phone Ext.
Date of Birth / / Social Security # Driver's License #
Employer

Primary Dental Insurance

Do you have a Primary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No
Company Name
Company Address City State Zip
Company Phone # **Individual ID# or SSN** **Group #** (Plan, Local or Policy #)
Subscriber's Name **Relationship to Patient**
Subscriber's Date of Birth / / **Subscriber's Employer**
Subscriber's Employee Address

Secondary Dental Insurance

Do you have a Secondary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No
Company Name
Company Address City State Zip
Company Phone # **Individual ID# or SSN** **Group #** (Plan, Local or Policy #)
Subscriber's Name **Relationship to Patient**
Subscriber's Date of Birth / / **Subscriber's Employer**
Subscriber's Employee Address

Dental Information

Previous or Referring Dentist: Phone Number:
When was your last dental visit? What was done?
When were x-rays taken last? **When was your last dental cleaning?**
Reason for today's visit: **Are you in pain?** ☐ Yes ☐ No For how long?
Please rate your current dental health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
How do you feel about your smile?
How many times a day do you brush? **How many times a week do you floss?**
What type of toothbrush do you use? ☐ Hard ☐ Medium ☐ Soft
Are you fearful of dental treatment? ☐ Yes ☐ No Please explain:
Have you ever had trouble getting numb or had reactions to local anesthetic? ☐ Yes ☐ No
Please describe:

Do your gums bleed?	☐ Yes	☐ No
Is your mouth dry?	☐ Yes	☐ No
Teeth sensitive to heat, cold, sweets, brushing, or flossing?	☐ Yes	☐ No
Have you noticed any bad tastes or bad breath?	☐ Yes	☐ No
Have you ever had periodontal (gum) treatments?	☐ Yes	☐ No
Have you had orthodontic (braces) treatment?	☐ Yes	☐ No
Does food tend to become caught between your teeth?	☐ Yes	☐ No
Have you had any problems associated with previous dental treatment?	☐ Yes	☐ No
Do you have earaches or neck pains?	☐ Yes	☐ No
Do you have any clicking, popping or discomfort in the jaw?	☐ Yes	☐ No
Have you noticed any loose or shifting teeth?	☐ Yes	☐ No
Have any of your family members had significant dental treatment or tooth loss?	☐ Yes	☐ No
Would you be concerned if you lost your teeth and had to wear false teeth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you had headaches on a regular basis in the morning, evening, or after eating?	☐ Yes	☐ No
Have you had your bite adjusted?	☐ Yes	☐ No
Do you have sores or ulcers in your mouth?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Have you ever had a serious injury to your head or mouth?	☐ Yes	☐ No
Do you participate in active recreational activities?	☐ Yes	☐ No

Health History

Please rate your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Date of last physical exam **Are you now under the care of a physician?** ☐ Yes ☐ No

Current Physician

What condition is being treated?
Physician Name **Phone Number**
Address City State Zip

For Women

Are you pregnant? ☐ Yes ☐ No How many weeks?
Taking birth control pills or hormonal replacement? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No
What was the illness or problem?
Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No
Please list any medications (prescription or over the counter) you are taking:

Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	

Do you need antibiotics prior to receiving dental care? ☐ Yes ☐ No Reason:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No

Date: Have you had any complications?

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No Date treatment began:

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How much do you typically drink in a week?

Allergies

Are you allergic to or have you had a reaction to:

Local anesthetics	☐ Yes ☐ No	Details:	
Aspirin	☐ Yes ☐ No	Details:	
Penicillin or other antibiotics	☐ Yes ☐ No	Specify:	
Barbiturates, sedatives, or sleeping pills	☐ Yes ☐ No	Details:	
Sulfa drugs	☐ Yes ☐ No	Details:	
Codeine or other narcotics	☐ Yes ☐ No	Details:	
Metals	☐ Yes ☐ No	Details:	
Latex (rubber)	☐ Yes ☐ No	Details:	
Iodine	☐ Yes ☐ No	Details:	
Hay fever/seasonal	☐ Yes ☐ No	Details:	
Food	☐ Yes ☐ No	Details:	
Other			

Medical Conditions

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

AIDS / HIV Positive	☐ Yes ☐ No	**Drug Addiction**	☐ Yes ☐ No	**Low Blood Pressure**	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	**Emphysema**	☐ Yes ☐ No	**Lung Disease**	☐ Yes ☐ No
Anaphylaxia	☐ Yes ☐ No	**Epilepsy or Seizures**	☐ Yes ☐ No	**Mitral Valve Prolapse**	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	**Excessive Thirst**	☐ Yes ☐ No	**Pain in Jaw Joints**	☐ Yes ☐ No
Angina	☐ Yes ☐ No	**Fainting Spells/Dizziness**	☐ Yes ☐ No	**Parathyroid Disease**	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	**Glaucoma**	☐ Yes ☐ No	**Psychiatric Care**	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	**Heart Attack/Failure**	☐ Yes ☐ No	**Radiation treatment**	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	**Heart Murmur**	☐ Yes ☐ No	**Rheumatic Fever**	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	**Heart Pace Maker**	☐ Yes ☐ No	**Scarlet Fever**	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	**Heart Trouble/Disease**	☐ Yes ☐ No	**Sickle Cell Disease**	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	**Hemophilia**	☐ Yes ☐ No	**Sinus Trouble**	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	**Hepatitis A, B or C**	☐ Yes ☐ No	**Stomach/Intestinal Disease**	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	**High Blood Pressure**	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	**Irregular Heartbeat**	☐ Yes ☐ No	**Thyroid Disease**	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	**Kidney Problems**	☐ Yes ☐ No	**Tuberculosis**	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	**Leukemia**	☐ Yes ☐ No	**Tumors/Growths**	☐ Yes ☐ No

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No

Please explain:

Confirmation

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____

OUR POLICIES

TREATMENT POLICY

Welcome to PerioWest! We are happy to have you as our patient and we are committed to providing you with the best possible care. We will recommend treatment that is based on the most current standards. Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements. Our goal is to give you the information you need to make an informed decision on what care is best for you.

APPOINTMENT POLICY

We see all patients on an appointment basis. Your appointment time is reserved specifically to meet your dental needs. We do ask that our patients arrive on time for their scheduled appointment. We recommend arriving 5-10 minutes early so that you can check in and fill out any additional information that might be needed. To schedule a surgical procedure a deposit will be required at the time of scheduling.

Missed Appointments. We understand that at times it may be necessary to reschedule an appointment. If that need should arise, please notify us at least three (3) business days for any procedure and at least two (2) business days for a non-procedural or hygiene appointment. This will give us an opportunity to reallocate someone who is in need of appointment. To cancel or reschedule your appointment, please call our office on a business day to speak with the front desk or leave a detailed message. Failure to give proper cancelation notice will result in a: 1) loss of your deposit ($1,000 maximum) for any procedure; or a 2) $50 fee for non-procedural or hygiene appointment.

FINANCIAL POLICY

Payments. Patients are expected to pay for our services at the time they are rendered, unless other arrangements have been made with the financial coordinators of the practice. For your convenience we accept cash, check, Visa, MasterCard and Discover. Third-party financing options offered at our office may also be available to you.

Dental Insurance Benefits. As a courtesy to our insured patients, we submit claims to your insurance company and will help you to receive your maximum allowable benefits. PerioWest is a provider for a Delta Dental PPO & Premier (excluding Group #216). Please note, we are not a provider for any state insurance plans or discount plans. We will submit insurance claims for all traditional insurance plans, other than the state plans, on your behalf and will do all we can to help in the processing of claims. For information on coverage, please call your insurance company or refer to your benefits manual. If we are unable to verify your insurance information before your appointment, you will be expected to pay for services rendered. Please note, insurance is a contract between you, your employer and the insurance company. We are NOT a party to that contract.

Please be aware that we do not submit any medical insurance claims. Should you decide to contact your medical insurance about possible medical benefits, we will release your dental records to you. Please note that all correspondence with medical insurance is the patient's responsibility.

Authorization to Release Information and Assignment of Benefits. I assign directly to PerioWest all dental insurance benefits, (if applicable), otherwise payable to me for services rendered. I hereby authorize the doctor and/or his staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

Estimates. As a courtesy, we will gladly contact your dental insurance in order to provide an *estimate* of your patient portion, if available. However, we cannot guarantee the payment of insurance benefits NOR can we provide 100% accuracy of this *estimated* amount, since many factors such as fee schedules, limitations, exclusions, waiting periods, etc. are involved that determine the actual payment of benefits once submitted and processed by your insurance. **Receiving our services indicates your acceptance and responsibility to pay regardless of estimate.**

Unpaid Insurance Claims. All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. Because your insurance policy is a contract between you (the patient) and your insurance carrier, it is your responsibility to contact your insurance carrier with any questions or disputes regarding the policy, covered treatments, and the amount that is covered. Should our office eventually receive a payment from your insurance after it has been paid by you, a refund will be issued.

Past-Due Accounts. If payment is not received by the due date printed on the statement, your account is considered "past due". Past due accounts will be charged 1.5% interest per month for all balances 60 days past due with a minimum finance charge of $1.50. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If account is assigned to a collection agency, you will be assessed 25% fee of the balance owed on your account. If it becomes necessary to assign your account to collections for any amount owed on this or subsequent visits, you agree to pay additional 40% of all costs and expenses, including reasonable attorney fees. For any returned "non-sufficient fund" checks, we will assess the bank fee for the return. This fee will not exceed $30.00.

Minor Patients. Minors (under the age of 18) must be accompanied by a parent or legal guardian at all their visits. The parent or legal guardian who accompanies the minor to the appointments is responsible for the *estimated* patient portion when treatment is rendered. Should the recommended treatment plan change, approval is required by the parent or legal guardian. The parent or legal guardian is required to notify our office of any changes in the minor's medical history prior to treatment.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all charges incurred, including those not covered by my dental insurance (if applicable). I agree to pay for the services rendered. If my insurance company denies payment, I agree to be personally responsible for payment.

PerioWest reserves the right to update and make changes the above-stated office policies at any time without prior notification.

Name: _____

Signature: _____ Date: _____

ACKNOWLEDGMENT AND CONSENT FOR USE OF NOTICE OF PRIVACY PRACTICES & DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY!

NOTICE OF PRIVACY PRACTICES: You have a right to read our Notice of Privacy Practices before deciding whether or not to sign this Consent. Your Notice of Privacy provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures you may make of my protected health information, and of other important matters about my protected health information. A copy of this Notice accompanies this Consent.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out Treatment, Payment, Activities, Healthcare Operations, Subpoenas, Immunization Information, Notice of Privacy Practices, Minnesota Healthcare Bill of Rights, Workers Compensation, Patient Access, Minors, Provider to Provider, Communication via email, text, USPS, Phone.

PURPOSE OF ACKNOWLEDGEMENT: By signing this form you acknowledge you had the opportunity to read our Notice of Privacy Act, effective date of 04/06/16. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Mariana Binus at 7810 Terrey Pine Court, Eden Prairie, Minnesota, 952-567-7858.

RIGHT TO REVOKE

You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if this Consent is revoked.

I, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Name: _____

Signature: _____ Date: _____

If this consent is signed by a Personal Representative on behalf of the patient, complete the following:

Personal Representative's Name: _____Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT