Renaissance
Family and Cosmetic Dentistry
Excellent Care . Exceptional Value

PATIENT INFORMATION

PATIENT LAST NAME FIRST MIDDLE	PREFERRED NAME TO BE CALLED	TODAY'S DATE	☐ MALE ☐ FEMALE

BIRTH DATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	CELL PHONE	CELL PROVIDER	MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP

MAILING ADDRESS	APT. OR SPACE NO.	CITY	STATE	ZIP CODE
HOME ADDRESS ☐SAME	APT. OR SPACE NO.	CITY	STATE	ZIP CODE

EMAIL ADDRESS

PERSON TO CONTACT IN EMERGENCY	RELATIONSHIP	PHONE	ADDRESS

HOW DID YOU HEAR ABOUT OUR OFFICE (CHECK ONE)?

☐GOOGLE/ONLINE ☐YELP ☐FRIEND/FAMILY ☐1-800-DENTIST ☐INSURANCE ☐OTHER:___________________________

RESPONSIBLE PARTY

PERSON RESPONSIBLE LAST NAME FIRST MIDDLE	RELATIONSHIP

HOME PHONE ☐ SAME	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE

HOME ADDRESS ☐ SAME AS ABOVE	CITY	STATE	ZIP CODE

EMPLOYER ☐ SELF ☐ NONE ☐ RET	BUSINESS ADDRESS	BUS. PHONE	OCCUPATION

IF PATIENT IS UNDER AGE 18

FULL TIME STUDENT ☐ YES ☐ NO	SCHOOL ATTENDING	CITY	GRADE

BOTH PARENTS NAMES	PARENTS MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? ☐Mo ☐Fa FINANCIAL CUSTODY? ☐Mo ☐Fa

PRIMARY DENTAL INSURANCE ☐ NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE	SUBSCRIBER'S BIRTH DATE

POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

SECONDARY DENTAL INSURANCE ☐ NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE	SUBSCRIBER'S BIRTH DATE

POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

Regarding Scheduled Appointments: We respect your time and do not "double-book" appointments. When you schedule an appointment with us, this time is reserved exclusively for you. Any change in the appointment affects many people. If you are unable to keep your appointment, please give us as much notice as possible, **preferably 48 hours**, so that we may offer this time to another patient. **We may charge up to $25 per half hour that we are unable to use as a result of a broken or cancelled appointment.**

Treatment Plan Estimates

Renaissance Family & Cosmetic Dentistry prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to us when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change. If you have dental insurance, it is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate of insurance benefits is based on information provided by your insurance company and by you. It is an estimate and your insurance benefits may be higher or lower than estimated. In all cases, you are responsible for amounts not covered by your insurance, unless prohibited by law or contractual agreement. A Predetermination of Benefits is not a guarantee of coverage. In all cases, we encourage all patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns relating to specific benefits.

Predetermination of Insurance Benefits

If you have insurance benefits, you may have the option to seek a Predetermination of Benefits before you proceed with any treatment.
Predetermination of Benefits is a process whereby your insurance company or plan administrator tells you in advance of treatment what procedures may be covered by your insurance plan, the amount the insurance company may pay toward those procedures, and the amount you may be required to pay. Requesting a Predetermination is like submitting a claim before the dental procedure or service has taken place.
Because the Predetermination comes directly from your insurer or plan administrator, the risk of error as to your coverage is reduced. If your treatment includes extensive or complex services, such as bridges, crowns, dentures or periodontal work, a Predetermination may be particularly helpful to allow you to appropriately budget for the services or discuss any potential alternative treatment that may be available, if necessary.
The Predetermination of Benefits process gives you useful information about what services may be covered. However, your insurer will inform you that a Predetermination of Benefits is not a guarantee of coverage. A Predetermination sets forth your expected benefits based on the information available to the insurer at the time the Predetermination is prepared. The Predetermination may not consider, for example, a prior claim submitted by another dentist for services provided to you, changes in your coverage that occur after the Predetermination is made but before the services actually are provided, or the insurance company's subsequent opinion that a condition could have been treated by a less costly alternative to the service provided by your dentist.
The time it takes to receive a Predetermination from your insurance company or plan administrator can vary, from as few as two weeks to as many as eight weeks. The decision to seek a Predetermination of Benefits or to proceed with treatment immediately is your own, unless your plan requires otherwise. Please inform the Practice Coordinator if you would like to request a Predetermination of Benefits from your insurer.

Payment Policy

In all cases, Renaissance Family & Cosmetic Dentistry patients agree to the following payment policies:

- Payment in full of the estimated patient portion of the fees is due no later than when services are rendered.
- For comprehensive treatment plans requiring multiple office visits and implant services, we require a minimum deposit of 50% of the total estimated patient portion of the fees at the start of treatment.
- Patients are always responsible for amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit, unless prohibited by law, or unless RFCD has a contractual agreement with my plan prohibiting all or a portion of such charges.
- Patients may, at their discretion, elect to pay in full, in advance for comprehensive treatment plans. Refunds for unused credit balances will be issued pursuant to our refund policy as stipulated in section IV, below.
- Patient will incur a $35 charge for each returned check. Any balance left unpaid for more than 30 days will be subject to interest charges at the rate of 1.5% per month.

We accept the following methods of Payment: Cash, Check, Money Order, Visa, Master card, Discover.
Payment plans: Care Credit, Healthy Teeth Plan

Refund Policy

Renaissance Family & Cosmetic Dentistry will refund any amount paid for treatment that you did not receive, except for RCFD's policy for Interrupted Services as set forth below. Also no refunds will be allowed for purchased products or services like teeth whitening, night guards, splints, diagnostic casts and wax ups, processed dentures.

Treatment Cancellation and Interrupted Services Charges

Patients requiring crown or bridge services (Not including Implant) may cancel treatment with no charge prior to natural teeth being prepared or altered for the prosthetic. Once tooth preparation occurs, patients are liable for the estimated full cost of the services even if they choose not to complete treatment.

Signature: ____ Date: _____________

CONSENT FOR SERVICES

I consent to the performing of dental procedures deemed to be necessary by the doctor. To the best of my knowledge this paperwork has been accurately answered. I will bring all future changes in my medical history to the attention of the doctor. I understand that providing incorrect or incomplete information can be dangerous to my health. I grant my permission to you or your assignee, to telephone me at home or at my work, or to send text messages or e-mails, to discuss matters related to this form and my oral health. I understand that during the course of treatment, certain unforeseen conditions may be revealed that may necessitate extension of the proposed procedure or a change from what was previously noted. If that occurs, I authorize the doctor and staff to perform such procedures as necessary and desirable in the exercise of professional judgment and I will be responsible for any associated fees. I authorize my insurance benefits to be paid directly to Renaissance Family and Cosmetic Dentistry. I understand and agree to the above conditions of treatment, the Notice of Privacy Practices, and the office Financial Policies and will be responsible for payment of my treatment. I authorize the doctor to release any and all photographs taken of the previously name patient for teaching purposes, for educational journals, and for marketing purposes.

Signature: ____ Date: ______________

HIPPA – ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Patient Name: ___________________________________

Patient Birth Date: _______________

We at Renaissance Family & Cosmetic Dentistry are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

____ ____________
Signature of patient or patient's representative/parent Date

____
Printed name of patient or patient's representative/parent

____
Relationship to patient

For Office Use Only - We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement 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):______________________________________

MEDICAL HISTORY

Patient Name: ______________________________________ Age: ____ Date: _______________

Name of Physician: __________________________________ Physician Phone #: ___________________

Date of last visit to physician: __________________________ Rate your general health: ☐ Poor ☐ Fair ☐ Good

PLEASE CHECK YES OR NO FOR THE FOLLOWING

Allergic reaction to:

YES	NO	
☐	☐	Aspirin, ibuprofen, acetaminophen
☐	☐	Penicillin
☐	☐	Erythromycin
☐	☐	Codeine
☐	☐	Local anesthetic
☐	☐	Latex
☐	☐	Metals (gold, stainless steel)
☐	☐	Any other medications _______________

Have had any of the following:

YES	NO	
☐	☐	Hospitalization for illness or injury
☐	☐	Artificial heart valve
☐	☐	Artificial Joints
☐	☐	Implants
☐	☐	Rheumatic fever
☐	☐	Scarlet fever
☐	☐	Heart problems (murmurs, etc.)
☐	☐	Heart disease
☐	☐	Heart attack
☐	☐	Chest pains / angina
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Low blood pressure
☐	☐	Dizziness or fainting
☐	☐	Pacemaker
☐	☐	Anemia / bleeding disorder
☐	☐	Prolonged bleeding due to a slight cut
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Asthma
☐	☐	Respiratory problems
☐	☐	Sinus problems
☐	☐	Hay fever, hives, skin rash
☐	☐	Kidney disease
☐	☐	Liver disease
☐	☐	Jaundice
☐	☐	Thyroid or parathyroid problems

YES	NO	
☐	☐	Hormone / endocrine problems
☐	☐	Diabetes
☐	☐	High Cholesterol
☐	☐	Stomach / digestive problems
☐	☐	Ulcers
☐	☐	Arthritis
☐	☐	Rheumatism
☐	☐	Glaucoma
☐	☐	Head or neck injury
☐	☐	Epilepsy / seizures
☐	☐	Venereal disease / STD
☐	☐	Hepatitis (type
☐	☐	AIDS/HIV
☐	☐	Tumor or abnormal growth
☐	☐	Cancer
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	Mood disorder / emotional problems
☐	☐	Nervous disorder
☐	☐	Psychiatric treatment
☐	☐	Antidepressant medication
☐	☐	Alcohol or drug dependency

Are you:

YES	NO	
☐	☐	presently being treated for any illness
☐	☐	Aware of a change in your general health
☐	☐	often exhausted or fatigued
☐	☐	A tobacco user
		Type _______________________
		Amount / Frequency ____________
		Do you want to quit _____________
☐	☐	considered a touchy person
☐	☐	often unhappy or depressed
☐	☐	easily upset or irritated
☐	☐	FEMALE – taking birth control pills
☐	☐	FEMALE - pregnant

Please describe any current medical treatment or impending surgery that may affect your dental treatment:

List ALL medications, vitamins, herbal supplements, or dietary supplements you are currently taking:

Do you now or have you previously taken any of the following medications: Yes ☐ No ☐

Coumadin/Warfarin Plavix Fen-phen/Redux/Pondimin Bisphosphonates (Fosamax, Boniva, Actonel, Zometa, Aredia)

Patient's Signature: ___________________________ **Doctor's Signature: ___________________**

DENTAL HISTORY

Previous Dentist: ____________________How long ago was last visit? ______________________

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?

____

How often do you have your teeth cleaned? 3 months ☐ 4 months ☐ 6 months ☐ 1 year or more ☐

How often do you brush your teeth? ______________________ How often do you floss? ________________

Rate your smile from 1 to 10 (with 10 being the best) ___________

Would you like to improve your smile? No ☐

Yes ☐ How? (Examples – Whitening, Braces, Veneers etc.) ___________________

Have you ever suffered from or been told you have any of the following:

GUM DISEASE	Yes	No
Bleeding, Swollen Gums?	☐	☐
Bad breath or taste?	☐	☐
Have you had deep cleaning?	☐	☐
Have you had Gum Surgery?	☐	☐

CAVITY – TOOTH DISEASE	Yes	No
Dental Pain?	☐	☐
Sensitivity to hot, cold, sweets?	☐	☐
Facial swelling or abscessed tooth?	☐	☐

OCCLUSAL DISEASE	Yes	No
Generalized Teeth sensitivity to hot or cold?	☐	☐
Notches on teeth near the gums?	☐	☐
Do you experience tension Headaches?	☐	☐
Wear patterns on the teeth?	☐	☐
Cracked teeth or cracked fillings?	☐	☐
Bone loss and teeth mobility with gum disease?	☐	☐
Do you awaken with an awareness of your teeth or jaws?	☐	☐
Are you aware of clenching or grinding your teeth?	☐	☐

TEMPORO MANDIBULAR DISEASE (TMJ DISORDERS)	Yes	No
Jaw clicking or popping?	☐	☐
Locked jaw?	☐	☐
Difficulty opening your mouth wide?	☐	☐
Experience difficulty chewing?	☐	☐
Wear patterns on the teeth?	☐	☐
Cracked teeth or cracked fillings?	☐	☐
Bone loss and teeth mobility with gum disease?	☐	☐

Tired facial muscles, stiff neck muscles?	☐	☐
Have you had trauma to head and neck region?	☐	☐
Have you had problems with other joints in the body, like pain?	☐	☐
Have you ever felt your bite is constantly changing?	☐	☐

Have you ever had braces? Yes ☐ No ☐

Do you currently wear any type of appliance? Yes ☐ No ☐

Do you have a dry mouth? Yes ☐ No ☐

Do you frequently have mouth sores (cold sores, canker sores)? Yes ☐ No ☐

Have you lost any teeth? Yes ☐ No ☐

Did you have any unfavorable dental experiences? Yes ☐ No ☐

Do you have anxiety about dental visits? Yes ☐ No ☐

Have you had problems with effectiveness of dental anesthetic? Yes ☐ No ☐

Do you have any difficulty swallowing or pain with swallowing? Yes ☐ No ☐

SUPPLEMENTAL DENTURE HISTORY (Please fill out if you are wearing a partial or complete denture)

YES	NO	PLEASE CHECK YES OR NO FOR THE FOLLOWING:
☐	☐	Has your present denture been relined? When ____
☐	☐	Is your present denture a problem? Describe ____
☐	☐	Satisfied with the appearance? ____
☐	☐	Satisfied with the comfort? ____
☐	☐	Satisfied with the chewing ability? ____
		When did you receive your first partial or complete denture? _________________________________
		How long have you work your present denture? ____

Patients Signature ___________________________ Doctors Signature __________________________