IMPORTANT DENTAL INSURANCE INFORMATION FOR OUR PATIENTS

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

OUR COURTESY SERVICE TO YOU INCLUDES:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of benefits available to you.
4. Re-filing your insurance a second time within 45 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance claims.

OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY:

1. Payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fees schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
5. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

I hereby authorize Trooper Dental Design to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Trooper Dental Design

IN ORDER TO ESTABLISH OPTIMAL RELATIONS WITH OUR PATIENTS AND AVOID MISUNDERSTANDING AND CONFUSION REGARDING OUR PAYMENT POLICIES, OUR STAFF IS TRAINED TO CONSISTENTLY INFORM YOU OF THE FINANCIAL PAYMENT POLICIES OF THIS OFFICE. PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED UNLESS WE HAVE MADE OTHER FINANCIAL ARRANGEMENTS. IN THE EVENT THAT YOUR ACCOUNT MUST BE TURNED OVER TO COLLECTIONS, A $35.00 COLLECTION FEE WILL BE ADDED TO YOUR ACCOUNT. WE ACCEPT PAYMENT IN THE FORM OF CASH, CHECKS OR CREDIT CARDS.

____________________________ Date________________

Signature of Patient/Insured

APPOINTMENTS THAT WE SCHEDULE FOR YOU ARE PUT ASIDE EXCLUSIVELY FOR YOU.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT WE REQUIRE 24 HOURS NOTICE TO AVOID AN ADDITIONAL FEE OF $50.00 WHICH IS NOT COVERED BY INSURANCE.

____________________________ Date________________

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date ____________________

Name ____________________

Birth date __________ SS# __________

Home Address ____________________

____

Single Married Divorced Widowed Separated

HM# ( ) __________ CELL# ( ) __________

WK# ( ) __________ EXT __________

Where & when are the best times to reach you? __________

Whom may we Thank for referring you? __________

Other family members seen by us: __________

Previous / Present Dentist: __________

Dentist Phone # ( ) __________ Last visit Date __________

SPOUSE INFORMATION

His/Her Name ____________________

Employer ____________________

WK# ( ) __________ EXT __________

SS# __________ Birth date __________

PERSON RESPONSIBLE FOR ACCOUNT

NAME ____________________

HM# ( ) __________ WK# ( ) __________

SS# ____________________

RELATIONSHIP ____________________

INSURANCE

PRIMARY INSURANCE

INSURANCE CO. NAME ____________________

INSURANCE CO. PHONE # ( ) __________

INSURED NAME ____________________

RELATIONSHIP ____________________

INSURED BIRTH DATE ____________________

GROUP/POLICY # ____________________

INSURED ID# ____________________

SECONDARY INSURANCE

INSURANCE CO. NAME ____________________

INSURANCE CO. PHONE # ( ) __________

INSURED NAME ____________________

RELATIONSHIP ____________________

INSURED BIRTH DATE ____________________

GROUP/POLICY # ____________________

INSURED ID# ____________________

MEDICAL HISTORY

DO YOU HAVE A PERSONAL PHYSICIAN YES NO

PHYSICIAN'S NAME ____________________

PHONE # ( ) __________

DATE OF LAST VISIT ____________________

ARE CURRENTLY UNDER THE CARE OF A PHYSICIAN YES NO

PLEASE EXPLAIN ____________________

____

MEDICAL HISTORY CONTINUED

YOUR CURRENT PHYSICAL HEALTH IS:

GOOD FAIR POOR

DO YOU SMOKE OR USE TOBACCO IN ANY OTHER FORM
YES NO

HAVE YOU HAD ANY METAL RODS, PINS OR IMPLANTS
YES NO

ARE YOU TAKING ANY PRESCRIPTION,
OVER-THE-COUNTER OR HERBAL SUPPLEMENT
YES NO

PLEASE LIST EACH ONE: ____________________

____

FOR WOMEN: Are you using a prescribed method of birth control? YES NO

Are you pregnant? YES NO

WEEK # __________

Are you nursing? YES NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS

Y N	Abnormal Bleeding	Y N	Hepatitis
Y N	Alcohol/Drug Abuse	Y N	Herpes
Y N	Anemia	Y N	High Blood Pressure
Y N	Arthritis	Y N	Hospitalized
Y N	Artificial Bones	Y N	Kidney Problems
Y N	Artificial Joints	Y N	Liver Disease
Y N	Artificial Valves	Y N	Low Blood Pressure
Y N	Asthma	Y N	Lupus
Y N	Blood Transfusion	Y N	Mitral Valve Prolapse
Y N	Cancer/Chemotherapy	Y N	Pace Maker
Y N	Colitis	Y N	Psychiatric Problems
Y N	Congenital Heart Defect	Y N	Radiation Tretment
Y N	Diabetes	Y N	Rheumatic Fever
Y N	Difficulty Breathing	Y N	Scarlet Fever
Y N	Emphysema	Y N	Seizures
Y N	Epilepsy	Y N	Shingles
Y N	Fainting Spells	Y N	Sickle Cell Disease
Y N	Fever Blisters	Y N	Sickle Cell Traits
Y N	Frequent Headaches	Y N	Sinus Problems
Y N	Glaucoma	Y N	Stroke
Y N	Hay Fever	Y N	Thyroid Problems
Y N	Heart attach/Surgery	Y N	Tuberculosis TB
Y N	Heart Murmur	Y N	Ulcers
		Y N	Venereal Disease

Anything you would like to discuss with the dentist in private? Y N

List any serious Medical conditions that you have ever had:

____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Codeine
Y N	Dental Anesthetic	Y N	Erythromycin
Y N	Jewelry/ Metal	Y N	Latex
Y N	Penicillin	Y N	Tetracycline

Please list any other drugs/materials that you are allergic to: _____

____

DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY? __________

____

Have you ever taken Fosamax, or any other bisphosphonate? Y N
Have you ever taken Phen-Fen? Y N
Do you require antibiotics before dental treatment? Y N
Are you currently in pain? Y N
Have you ever had a serious / difficult problem associated with any previous dental work? Y N
Have you ever had gum treatment? Y N

Your current dental health is Good Fair Poor

Do you like your smile? Y N Do your gums ever bleed? Y N
How many times a week do you floss? _____ a day you brush? _____
Type of bristles? Hard Medium Soft
How long do you use a toothbrush before replacing it? __________
Are your teeth sensitive to heat, cold, or anything else? __________
Have you lost any teeth? Y N
If yes, why? __________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that thin information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature Date

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

This office accepts insurance and I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CD and the ADA.

I verbally reviewed the medical / dental information above with the patient named herein. Initials: __________ Date: __________