SEABLUE DENTAL

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info@seabluedental.com
www.seabluedental.com

PATIENT'S INFORMATION

Date _____

Patient Name	Preferred Name	Social Security #
Home Address	Apt#	Birthdate
	City, State, Zip	Gender ☐Male ☐Female
Email Address	Cell Phone	Work Phone
Marital Status ☐Single ☐Divorced ☐Married ☐Separated	Home Phone	Driver's License# and State

Preferred Method of Confirmation: ☐Text ☐Call ☐Email

Emergency Contact Info_____Relation_____Phone_____

I authorize Seablue Dental to communicate my health information and treatment plan with _____
Relation_____ Phone _____ in my absence.

RESPONSIBLE PARTY – INSURANCE / PAYMENTS

Name	Social Security #	Birthdate	
Home Address	Apt#	Cell Phone	
	City, State, Zip	Home Phone	
Marital Status ☐Single ☐Divorced ☐Married ☐Separated	Relationship to Patient	Driver's License# and State	

Primary Insurance Company_____Group_____Subscriber_____

Secondary Insurance Company _____Group_____ Subscriber_____

Responsible Person's Employer	Occupation	Work Phone	
Business Address	City	State	Zip

GENERAL DENTAL QUESTIONAIRE

Name of previous Dentist _____ Date of last visit _____ Last Full Mouth X-rays_____

Reason for changing dentist? _____ Phone# / Website _____

How often do you visit the dentist? ☐ Regulary ☐ Occasionally ☐ As Needed ☐ First Visit

How often do you floss? ☐ Regularly (1x/day) ☐ Occasionally (1x/week ☐ Rarely (1x/mo. Or less)

How often do you brush? ☐ Regularly (1-2x/day) ☐ Occasionally (1x/week) ☐ Rarely (1x/mo. Or less)

What are your dental priorities? (appearance, dental health, financial considerations, etc.)

☐Y ☐ N I would like to improve my smile.
☐Y ☐ N I want my teeth whiter.
☐Y ☐ N I want regular dental care & improve my oral wellbeing.

Other_____

How did you hear about our Office? *(check all that apply)*

☐Referred ☐Website ☐Online ☐Insurance ☐Health Fair/Community Event ☐Drive by/Signage ☐Other_____

Who selected this office? ☐Self ☐Spouse ☐Parent ☐Employer

If you were referred, whom may we thank for referring you? _____

DENTAL HISTORY & CONCERN (Check all that apply)

Concerns	Y	N	Concerns	Y	N	Concerns	Y	N	Concerns	Y	N
Broken / Chipped Teeth	☐	☐	Bad Breath	☐	☐	Popping / Clicking	☐	☐	Mouth Sores	☐	☐
Lose Teeth	☐	☐	Sensitivity to Bite	☐	☐	Difficulty Opening / Closing	☐	☐	Red / Puffy Gums	☐	☐
Food Traps	☐	☐	Tooth Pain - Generalized	☐	☐	I Bite My Nails	☐	☐	I am a Tobacco User	☐	☐
Missing or Lost Filling	☐	☐	Stain / Discoloration	☐	☐	Cheek Biting	☐	☐	Gum Recession	☐	☐
Sensitivity to Hot / Cold	☐	☐	Clenching / Grinding	☐	☐	Sleep Apnea	☐	☐	Wisdom Teeth (3rd Molars)	☐	☐
Decay / Cavity	☐	☐	Sensitivity to Sweets	☐	☐	I Use CPAP	☐	☐	Avoid Chewing - L / R	☐	☐
Missing Teeth	☐	☐	Jaw Pain / Injury	☐	☐	Snoring	☐	☐	Crooked / Misaligned Teeth	☐	☐
Dental Phobia	☐	☐	Frequent Headaches	☐	☐	Bleeding / Swollen Gums	☐	☐	I wear a Retainer	☐	☐
Difficulty Chewing	☐	☐	Pain in Temples	☐	☐	Dry Mouth	☐	☐	I wear a Nightguard	☐	☐

TREATMENT CONSENT

Thank you for choosing Seablue Dental as your dental home! Our office wants all our patients to enjoy the benefits of good oral health and maintain a healthy and attractive smile throughout their life. For our patients to be able to comfortably afford their dental care, we offer various financial choices and payment options. The following is a statement of our office and financial payment policy, which we request you read and sign prior to your treatment. If you have any questions, please ask. We are here to help!

After explanation by the doctor, I hereby authorize the performance of dental services upon the above-named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor

X_____

Patient's (or legal guardian) Signature Name of the Patient Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have had full opportunity to read and consider the contents of the Notice of Privacy Policies. I understand that I am giving my permission to your use and disclosure of my protected health information (PHI) in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke the permissions I am granting.

X_____

Patient's (or legal guardian) Signature Name of the Patient Date

PATIENT'S MEDICAL HISTORY

_____

Patient's Name **Date of Birth**

A thorough medical history is essential to a complete dental evaluation. Your answers are for the records only and are confidential.

Condition	Y	N		Condition	Y	N
Are you under a Physician's care now?	☐	☐		Do you use tobacco?	☐	☐
Have you ever been hospitalized or had a major operation?	☐	☐		Do you use any controlled substance?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐		Are you Pregnant or trying to be?	☐	☐
Do you take or have you taken Fosamax or Bisphosphonate?	☐	☐		Are you nursing?	☐	☐
Are you taking any blood thinner – Plavix, Heparin or Coumadin?	☐	☐		Are you taking oral contraceptives?	☐	☐

Are you allergic to any of the following? (Check all that apply)

☐Aspirin ☐Penicillin ☐Codeine ☐Sulfa ☐Amoxicillin ☐Nitrous Oxide ☐Acrylic ☐Latex ☐Local Anesthetics ☐ Metal ☐Other

If Yes, please explain: _____

Are you taking any medications, pills or drugs? ☐Yes ☐No

If yes, please list all medications: _____

_____

MEDICAL HISTORY (Check all that apply)

Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N
AIDS/HIV Positive	☐	☐	Dizziness	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Alzheimer's Disease	☐	☐	Drug Addiction	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Angina	☐	☐	Epilepsy or Seizures	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Anaphylaxis	☐	☐	Excessive Bleeding	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Arthritis/Gout	☐	☐	Excessive Thirst	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Artificial Joints	☐	☐	Fainting Spells/Dizziness	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐
Asthma	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Breathing Problem	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Easy bruising	☐	☐	Hay fever	☐	☐	Mitral Valve Prolapses	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Heart Attack/ Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Chest Pain/Discomfort	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
Congenital Heart Disease	☐	☐	Hemophilia	☐	☐	Radiation Treatments	☐	☐	Yellow Jaundice	☐	☐
Convulsions	☐	☐	Hepatitis B or C	☐	☐	Rheumatic Fever	☐	☐		☐	☐
Cortisone Medicine	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐		☐	☐
Diabetes	☐	☐	Herpes	☐	☐	Renal Dialysis	☐	☐		☐	☐

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 my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____

Patient's (or legal guardian) Signature Name of the Patient Date

SEABLUE DENTAL OFFICE POLICIES

BILLING POLICY (Please read and initial the following)

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

1. Seablue Dental provides emergency treatment for new patients on a cash basis. Payment in full is expected on the day of treatment.
2. Unless otherwise agreed in writing, all accounts are due within 60 days from the date of treatment. Past due accounts will be charged a finance fee of 1.5% a month or 18% annually. There is $40 fee for returned checks.
3. If you have dental insurance, we will be happy to submit claims on your behalf and help maximize the benefits available to you. However, the contract for payment exists between you and Seablue Dental, regardless of how the fees are processed by your insurance carrier.
4. All procedures that require lab work (crowns, inlays/onlays, bridges, partials/complete dentures, retainers, implants etc.) require at least ½ of the fee at the prep appointment.
5. As a condition of treatment by this office, I understand financial arrangements must be made in advance. Payments may be made with Cash, Check, Debit, Credit or CareCredit. A surcharge of 3.0% will be added to payments paid with credit cards. Payments made with personal check should be made 1-week prior to the appointment.
6. We offer our private pay patients a 5% discount for accounts paid in full by cash or check the day of service. This cannot be combined with any other discounts and promotions offered by the office.

Assignment of Insurance: I hereby authorize release of any information needed & authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that the fee estimate for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security# or any other information I have given to you. I agree that in the event, either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

_____(Initials)

APPOINTMENT CANCELLATION & RECORDS TRANSFER POLICY

We strive to render excellent dental care to all our patients. To be consistent with this, we have the following policies for appointment changes and record transfer that allows us to efficiently schedule & maintain patients' appointments.

1. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient We require **48 hours** advance notification should you need to reschedule or cancel your appointment. This is the time required for us to refill the timeslot earlier reserved for you. If you miss an appointment without contacting our office within the required time, this is considered a "no show".
2. A **fee of $50 per hour on weekdays and $75 per hour on weekends** of the total appointment time will be charged for a "no show" or short notice cancellation. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.
3. Seablue Dental reserves the right to dismiss patients with multiple "no shows" or late cancellations from the practice.
4. A **fee of $20** is charged for the transfer the x-rays via email or fax to other medical facility.

_____(Initials)

X_____

Patient's (or legal guardian) Signature Name of the Patient Date