Nielson Dentistry, Eric R. Nielson DMD, PLC

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Date of birth: _____ Gender: _____

Phone (Home): _____ (cell): _____ Marital Status (for insurance): _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency contact: name: _____ phone# _____

Health Information

Date of LAST Dental Cleaning: _____ Reason for TODAY'S visit: _____

Have you ever had any of the following? Please check Yes or No:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Diabetes	☐	☐	Jaundice	☐	☐	Stomach Problems
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Stroke (date)_____
☐	☐	Angina	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Fainting	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers/Canker sores
☐	☐	Artificial Joints	☐	☐	Glaucoma	☐	☐	Pacemaker	☐	☐	Penicillin Allergy
☐	☐	Asthma	☐	☐	Hay Fever	☐	☐	Current Pregnancy	OTHER:		
☐	☐	Blood Disease	☐	☐	Head Injuries			Due date:_____	☐		_____
☐	☐	Cancer	☐	☐	Heart Attack	☐	☐	Radiation Treatment			
☐	☐	Chemotherapy	☐	☐	Heart Murmur	☐	☐	Respiratory Problems			
☐	☐	Cold sores/fever blisters	☐	☐	Hepatitis	☐	☐	Rheumatic Fever			
			☐	☐	High Blood Pressure	☐	☐	Sinus Problems			

- Are you happy with your smile? ☐ Yes ☐ No
  If no, what would you change? _____
- Do you have any artificial joints or a heart condition that requires an antibiotic? ☐ Yes ☐ No
- Are you currently taking any medications (including over the counter medications)? ☐ Yes ☐ No
  If yes, please list: _____
  _____
- Have you ever taken Fosamax, Boniva, Actonel, or any other bisphosphonate? ☐ Yes ☐ No
  If yes, when: _____
- Are you taking any blood thinners/anticoagulant drugs? ☐ Yes ☐ No
  Date of last INR and INR # : _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Dentist

Referral Information

How did you find out about our practice?
☐ Insurance Co._____ ☐ Web search_____ ☐ Friend/Relative_____

How would you rate our website? (www.nielsondentistry.com) excellent good fair poor (circle one)

Responsible Party Information (If same as patient, leave blank)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

As you know, appointment times are valuable. Therefore, we ask that you notify our office in the event you need to cancel or reschedule your appointment.
(1 business day is required)

I understand there is a $70.00 an hour "broken appointment fee" in the event I do not notify the office 1 business day prior to the appointment time.

_____
Print Patient Name

_____ _____
Signature of Patient or Guardian Date

Nielson Dentistry

3035 South Ellsworth Rd. #138
Mesa, AZ 85212
(480)357-9442

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that, under the Insurance Portability & Accountability Act of 1996 (HIPAA), I have the right to privacy regarding my protected health information. I understand that this information can and be used to:
-Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
-Obtain payment from third-party payers.
-Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

NIELSON
DENTISTRY

ERIC R. NIELSON DMD, PLC

FINANCIAL POLICY FOR OUR PATIENTS

Our office wants all our patients to be able to comfortably afford dental care. We proudly offer the following policy so that our patients can have the opportunity to decide which payment option best suits your needs.

Insurance: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Because of this, you will be asked to pay your deductible and your co-payment for the charges on the day the service is rendered. Also for **all treatment under $100, excluding preventive treatment, you will be asked to pay in full.** We will estimate as closely as possible your coverage, but we can make no guarantee of any estimated coverage.

Because the insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the total balance.

Payment Options

1. **Cash or Check.** We are happy to offer a 5% pre-payment courtesy for all treatment paid in full in advance of treatment.
2. **Credit Card.** Our office accepts VISA, MasterCard, Discover, and American Express.
3. **Outside Financing.** Care Credit. Please ask for details.
4. **Sr. Citizen Discount.** As a courtesy to anyone 60 years or older, we will gladly discount your fee by 10% if services are paid at the time of service.