



We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us- we will be happy to help you.

**Whom may we thank for referring you?**

\_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_/\_\_/\_\_  Male  Female

Email Address:

\_\_\_\_\_

Social Security \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Address:

\_\_\_\_\_  
(Street) (City/town) (State) (Zip Code)

Home Phone :(\_\_\_\_) \_\_\_\_\_ Work :(\_\_\_\_) \_\_\_\_\_ Cell Phone :(\_\_\_\_)

\_\_\_\_\_

Employer: \_\_\_\_\_

Guardian/Parent Name (if patient is minor) \_\_\_\_\_ Date of birth

\_\_\_\_\_

Driver License \_\_\_\_\_ Social Security \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone

\_\_\_\_\_

**Dental Insurance information**

Do you have Dental Insurance?  Yes  No

If you have dental insurance, please complete section below: *If no insurance ask*

**Dental Insurance**

Company \_\_\_\_\_

Address \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber ID # \_\_\_\_\_

Subscriber's Date of Birth \_\_/\_\_/\_\_

Subscriber's Social Security Number \_\_ / \_\_ / \_\_\_\_\_

Group/Policy # \_\_\_\_\_

Employer Name \_\_\_\_\_



**Medical and Dental History**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Why are you here today?

\_\_\_\_\_

Are you having pain or discomfort at this time? Yes No

If yes, what type and where?

\_\_\_\_\_

Have you been under the care of a medical doctor during the past two years? Yes No

Are you taking any medication now?  Yes No If yes please list

\_\_\_\_\_

Has a dentist/physician ever told you that you need to take antibiotics before having dental treatment? Yes No

Do you use tobacco products (smoke or chew tobacco)? Yes No

Do you drink alcoholic beverages (beer, wine, whiskey, etc)? Yes No

Do you have any allergies? If yes, please check all that apply: Yes No

Penicillin  Antibiotics  Anesthetics  Aspirin  Latex  Other:

\_\_\_\_\_

What do you do to take care of your teeth and gums?

Daily tooth brushing  Daily flossing  Electric Toothbrush  Water Jet Device

**Please circle any illnesses or conditions you may have or ever had:**

Alcohol Abuse	Drug Abuse	Psychiatric care/Emotional Problems
Allergies to Medicine(s)	Diabetes	Rheumatic Fever
Anemia or blood problems	Epilepsy	Shingles
Any Heart Ailments or Problems	Glaucoma	Sinus Problems
Arthritis	Hay Fever	Stroke
Artificial Joint	Heart Murmur	Seizures
Asthma	Hepatitis A, B, C	Thyroid Problems
Blood Transfusion	High Blood Pressure	Tuberculosis
Bruise Easily	Heart Surgery	Ulcer or Colitis
Cancer or Chemotherapy	Immune System, HIV, AIDS, ARC	Sexually Transmitted Disease
Chronic Cough	Kidney Problems	Sickle Cell Disease
Cold Sores/ Fever Blisters/ Herpes	Liver Problems	Yellow Jaundice

Do you have any other health conditions? Yes No

If yes, please list.

\_\_\_\_\_

**For Women Only:**

Are you pregnant  Yes  No  
If yes, what month? \_\_\_\_\_  
Are you nursing  Yes  No Are you taking birth control pills?  
Yes  No

**I understand the above information is necessary to provide me with dental care in a safe and efficient matter. I have answered all questions truthfully.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dentist's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Appointments**

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least 2 working days advanced notification so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. There may be a \$50 fee for missed appointments and cancelled appointments without prior notice. We value your time, please value ours.

**Please note, Patients who miss any appointments on Saturday without prior notice, will not be scheduled on a Saturday anymore.**

**Confirmations**

We use emails and text messages as appointment reminders and important messages. You will be sent an initial email or text to opt in to this reminder system.

**Authorization And Consent**

**Assignment of Insurance Benefits**

\_\_\_ I authorize and request my insurance company to pay my benefits directly to Horizon Dental Care.

**Notice of Privacy Practices**

\_\_\_ I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.

\_\_\_ I understand that I may ask questions that I might have regarding this notice.

**Photography Consent**

\_\_\_ I authorize Dr Mughrabi and any associates of Horizon Dental Care to take photographs/x-rays of me to help me better understand my current dental condition and possible treatment options.

\_\_\_ I understand and will comply with office **Appointment Policy**.

\_\_\_ I understand and will comply with the office **Financial Policy**.

\_\_\_ I understand and agree to the **General Consent to Treatment**.

\_\_\_ I understand and agree to the **Notice of Privacy Practices**.

X \_\_\_\_\_

Signature of Patient, parent, or guardian

Date



## Our Financial Policy

Please read carefully and sign.

- **FULL PAYMENT IS DUE AND PAYABLE AT THE TIME OF SERVICE.**
- We accept **CASH, CHECKS, VISA, MC, AMERICAN EXPRESS, DISCOVER AND CARE CREDIT** (NO INTEREST OR LOW INTEREST HEALTHCARE FINANCING PROGRAM). Any special arrangements must be discussed and approved by our billing manager prior to the start of treatment.
- **For patients with insurance**, we will gladly submit your insurance claims for you. Estimated deductibles and co-pays are due and payable at the time of service. We do not, however, submit for reimbursement from Flex Spending Accounts FSA or Health Savings accounts (HSA). The patient is responsible for paying our office for services and submitting their own reimbursement claims.
- **For Minor patients**, the adult accompanying the minor is responsible for full payment at the time of service.
- **All balances on billing statements are due and payable upon receipt.** You are responsible for all fees for treatment rendered regardless of your status as an active or inactive patient.
- **Returned check fee is \$45 and is non refundable. We reserve the right to refuse payment by check thereafter.**
- **Delinquent accounts:** Patients with delinquent accounts will be required to make full payment on account prior to making appointments for any additional treatment. A late fee of \$30 will be applied to all accounts overdue more than 60 days from the date of service. Interest at the rate of 1-1 ½% per month will be applied to such accounts. You are responsible for costs associated with the collections of a delinquent account including reasonable attorney fees and court costs. The doctors authorized to disclose portions of the patient's dental record to the extent necessary to determine liability for payment and to obtain reimbursement. Furthermore, you may be dismissed from the practice.
- **Cancellation/missed appointments:** We require 48 hour advanced notice for any cancellations. We do not accept cancellation via our voice mail or email systems, you must speak with a staff member. A \$50 broken appointment will be assessed if proper notification is not given. Frequent missed or cancelled appointments can lead to dismissal from the practice.

**Insurance:** It is our pleasure to assist you in maximizing your insurance benefits and as a courtesy; we will file your claims for you. We will estimate your patient portion not covered by insurance, and this amount will be due and payable at the time of service. As it is impossible to know the details of every insurance policy, our estimate may differ from the actual coverage. Our practice is committed to providing the best treatment for our patients and we set our fees based on the quality of treatment we provide. The insurance is a contract between you and your insurance company. You are ultimately responsible for the fees on the account regardless of insurance coverage. Insurance is not a substitute for payment.

**Furthermore:**

- You must provide our office with complete and accurate billing information prior to treatment, including current insurance card. If we cannot verify your policy, you will be asked to make full payment.
- We want you to know and understand your insurance coverage. If you have any questions please ask us.
- You are responsible for all charges not covered by your insurance. This includes co-payments, deductibles and fees for non covered services. If after 60 days your claim remains unpaid by your insurance company you will become responsible for the amount. If the claim is paid you will be refunded the claim amount.
- You Authorize Dr. Mughrabi and any associates of Horizon Dental Care to submit claims and assign benefits to the billing provider. Assignment of benefits will remain in effect until revoked in writing. A photocopy of this assignment is considered as valid as an original.

If you have any questions regarding our financial policy please do not hesitate to ask.

Patient Signature or parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_