Welcome

We are pleased to welcome you to our practice. Please take a few minutes to complete this form.

Patient Information

Name_____ Date_____

Address_____

City_____ State _____ Zip_____

Phone home_____ Office_____ Cell _____

Male___ Female___ Birth date _____Social Security Number_____

Single ____ Married ____ Widowed ____ Divorced ____

Email Address_____

Patient employed by_____Occupation_____

Business Address_____

Whom may we thank for referring you?_____

In case of emergency please contact_____

Phone _____ Relationship_____

Insurance Information

Person responsible for account_____

Relationship to the patient _____Birth date_____ Social Security #_____

Address (if different from patient) _____

City_____ State_____ Zip_____

Business Name/Phone_____

Insurance Company Name/Phone_____

MEDICAL HEALTH HISTORY PATIENT NAME: _____ Date: _____

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain: _____
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____

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4. Yes No Are you being treated by a physician now? For what? _____

Name of your physician: _____ Date of last Medical Exam: _____

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Joint pain, stiffness
14. Yes No Jaundice
15. Yes No Dizziness
16. Yes No Ringing in ears
17. Yes No Frequent Headaches
18. Yes No Fainting spells
19. Yes No Blurred Vision
20. Yes No Seizures
21. Yes No Excessive thirst
22. Yes No Frequent urination
23. Yes No Dry Mouth
24. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

25. Yes No Heart disease
26. Yes No Heart attack, heart defects,
27. Yes No Heart murmur
28. Yes No Rheumatic fever
29. Yes No Stroke, hardening of arteries
30. Yes No High Blood Pressure
31. Yes No TB, emphysema or other lung diseases
32. Yes No Hepatitis, A B C
33. Yes No Stomach problems, ulcers
34. Yes No Diabetes
35. Yes No Mitral Valve Prolapse
36. Yes No HIV positive or AIDS-ARC
37. Yes No Tumors, Cancer
38. Yes No Arthritis, rheumatism
39. Yes No Eye disease
40. Yes No Skin disease
41. Yes No Anemia
42. Yes No VD (syphilis or gonorrhea)
43. Yes No Herpes
44. Yes No Kidney, bladder diseases
45. Yes No Thyroid, adrenal diseases
46. Yes No History of diabetes, heart problems, cancer

D. DO YOU HAVE OR HAVE YOU HAD:

47. Yes No Surgeries _____
48. Yes No Blood Transfusions _____
49. Yes No Artificial Joint _____
50. Yes No Contact Lenses _____
51. Yes No Psychiatric Care _____
52. Yes No Radiation Treatments
53. Yes No Chemotherapy
54. Yes No Prosthetic heart valve
55. Yes No Pacemaker
56. Yes No Birth Control Pills (**Women only)**
57. Yes No Pregnant or nursing **(Women only)**

E. DO YOU TAKE OR HAVE TAKEN:

58. Yes No Recreational drugs
59. Yes No Alcohol
60. Yes No Tobacco in any forms
61. Yes No Phen Phen diet Pills or any other diet pills
62. Yes No Fosamax

F. VITAMINS & MEDICATIONS: _____

_____

_____

ALLERGIES: **LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:**

_____

G. ALL PATIENTS:

63. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

64. Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?

DENTAL HEALTH HISTORY

H. Name of your Former Dentist: _____ How long since you were last seen? _____

65. Is keeping your teeth important to you? [Y] [N] If yes, why? _____
66. On a scale of 1-10, 10 being the best, where would you rate your smile?
67. On a scale of 1-10, 10 being the best, where you rate your oral health?
68. Have you experienced any of the following problems:

Bleeding gums [Y] [N],	Sensitivity to Hot & Cold [Y] [N]
Bad Breath or sour taste in mouth [Y] [N]	Snoring [Y] [N]
Burning sensations in mouth [Y] [N]	Food catching between teeth [Y] [N]
Soreness in jaw [Y] [N],	Clenching or Grinding of Teeth [Y] [N]
Is it hard for you to open wide? [Y] [N]	Pain/soreness around ears, eyes, face [Y] [N]
Clicking or popping in jaw [Y] [N]	Stiff neck muscles [Y] [N]
Have you or your parents suffer(ed) from Gum Disease? [Y] [N]	Do you or your parents wear dentures/partials? [Y] [N]
Did you ever wear braces? [Y] [N]	Ever been injured in your mouth or head? [Y] [N]
Oral Surgery of any kind? [Y] [N]	Do you smoke or chew tobacco? [Y] [N]

70. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

_____ _____

71. Is the brightness of your teeth important to you? [Y] [N]

72. If you could change anything about your smile which of the following would you want?

Whiter [Y] [N]	Close space or spaces [Y] [N]	Replace chipped teeth [Y] [N]
Replace missing teeth [Y] [N]	Replace old crowns [Y] [N]	Remove silver fillings [Y] [N]
Remove Stains/Spots on teeth [Y] [N]	Excess showing of Teeth [Y] [N]	Replace old plastic filling(s) [Y] [N]
Straighter [Y] [N]	Less Gum showing [Y] [N]	Reshape/resize my teeth [Y [N]

73. Fill in this question for us please: Where do you see your overall oral health and/or your smile in the next 5 to 10 years?

74. **Please circle the following which are important to you when making your dental health decision.**

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Photographic Release

In our office we like to photograph our patients to aid Dr. Titensor in determining dental problems and the solutions/treatment options for them. Dr. Titensor sometimes uses the photographs, with the patients permission, to teach dentists all over the world how we create beautiful smiles for our patients.

We are very proud of the work we have done and use only our own patients photographs in our marketing and advertising. All of the portraits in our office and on the website (www.titensordental.com) and in our ads are our own patients.

Authorization and release:
I hereby authorize Dr. Titensor to use photo's of my face, jaws, and teeth. I understand that the photos may be used as a record of my care and may be used for educational purposes in lectures, demonstrations, and advertising. (Including website, magazines, phonebooks, television) and professional publications. I further understand that if my photo's are used in any way described above that my name and identifying information will be confidential. I do not expect compensation, financial or otherwise for use of these photos.

Patient signature:_____ Date:_____

X-ray Information

X-rays provide invaluable information to Dr. Titensor for diagnosing and treatment planning. To provide a comprehensive examination, x-rays are required. There are a variety of x-rays; each provides a variety of information. Dr. Titensor will recommend x-rays based on your individual needs.

Our x-ray system is digital which results in the lowest possible exposure to radiation. We are able to view the films immediately.

Insurance companies limit the types and the frequency that some x-rays are taken. It is our responsibility to provide a comprehensive evaluation to you. By limiting the allowance of x-rays Dr. Titensor cannot present a complete evaluation to you. If there are x-rays recommended to you that are declined, we will require a signed release of liability from you stating that you fully understand that there are conditions that cannot be diagnosed without them.

I have read the information regarding x-rays and fully understand Dr.Titensor's philosophy. I understand that my insurance company limits frequency of some types of x-rays and if I am in a situation that requires services not covered, I will be responsible for the fee's associated with the service.

Patient signature:_____ Date:_____

Our Financial Philosophy

Thank you for selecting our office for your dental care. It is important to us that the quality of our business services match the quality of your dentistry. We want the handling of your account, from the start, through final payments to be perceived as an extension of the dental care we provide you and your family.

Patients Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service resulting in successful treatment. In turn, your role is to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

In developing a financial arrangement, it is important to remember your dental future. Our experience has shown that when an account lingers patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short amount of time as is comfortable for both of us.

Regarding Insurance

We will gladly file dental claims for your treatment once your coverage and benefits have been verified. We ask all patients to complete our Patient Information Packet before seeing the doctor as that ensures we have obtained the correct information to better serve you in regards to your benefits. Your ***estimated*** co-pay and deductibles will be collected as treatment progresses. These numbers are only ***estimates***, as your insurance company is unable to provide exact information to us because your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Also for this reason, if your policy is based on a fee schedule, you will need to provide our office with a copy of that schedule.

We may accept assignment of insurance benefits, however the balance is your financial responsibility regardless of what insurance doesn't cover. We ask that you provide us with complete and accurate insurance information so we may file to your insurance company. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you and will be due upon billing.

- ☐ **Yes, please file a claim to my insurance provider on my behalf.**
- ☐ **No, I DO NOT want you to file a claim. I will pay in full and file my own claim.**
- ☐ **What is your preferred method of payment? _____**

WE ACCEPT CASH, CHECK, VISA, MASTER CARD, DISCOVER AND AMERICAN EXPRESS

WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Dr. Titensor must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Dr. Titensor.**

Thank you for reading our Financial Alliance. Please let us know if you have any questions or concerns. I have read the Financial Alliance. I understand, accept and agree to this Financial Alliance.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Financial Coordinator Date

Pre-Authorized Payment

☐ **If my insurance company doesn't pay within 45 days, I authorize Dr. Titensor's office to charge the following account for the balance. If the amount is over $100 a courtesy call will be made prior to charging the credit card.**

CARD NUMBER: _____ **EXP. DATE:** _____ CVV: _____

_____ _____

Name on Card **Signature**

Missed Appointments

We require a minimum of 48 hour's notice if you need to cancel or change an appointment. Not providing this notice may result in a charge. Furthermore, if we are unable to confirm your upcoming appointment either by phone or email, we may release your appointment time to another patient.

_____ _____

Signature of Patient or Responsible Party Date

Facts You Should Know About Your Insurance Benefits

Dental insurance has become a major factor in helping people obtain necessary dental treatment. We feel our patients deserve the best in dental treatment with the maximum in dental benefits and we would like to share some general facts about dental insurance.

FACT # 1. Were you aware that dental insurance is not meant to be a PAY-ALL? It is only meant to be an aid to you, THE PATIENT. When making decisions about your dental health, who do you want to aid you in your decision-making: the insurance business who only wants to make a profit, or someone who has only your well-being as their top priority?

FACT # 2. Did you know that many plans tell their insured (YOU) that they will be covered "up to 80% or up to 100%"? In spite of what you're told, most plans cover about 50%-60% of an average fee that is set by the insurance carrier. Some plans pay more—some less. Were you aware that the amount your plan pays is determined by how much your employer paid for the plan? Unfortunately, the less money paid for the plan, the less benefit you will receive.

FACT # 3. The insurance company should say: "our benefits are low for your plan". Remember, you get back only what your employer puts in, minus the profits of your insurance company. Many insurance companies tell insured members that their doctors' fees are "above the usual and customary fees", which may lead the patient to believe that they are being overcharged. Guess who sets those fees? The Insurance Company!

FACT # 4. Did you also know that many routine dental services are NOT covered by insurance policies? Many services are "underwritten with restrictions or no coverage" due to how much the employer wants to spend on the benefit plan.

FACT # 5. We hope that you will be happy with our services and the quality of dentistry that you deserve and will receive from our practice. Fortunately for our patients, we will not allow any insurance company to dictate the fees or compromise the quality of care you will receive from our practice. We provide a service for a fee and will help you to maximize your dental benefits. To ensure the ultimate oral health of all of our patients, we cannot take responsibility for what insurance carriers will or will not pay.

Please do not hesitate to ask any questions about your benefits with our experts. We want you to be comfortable in dealing with these matters and we urge you to consult with us if you have any questions regarding our services. As a courtesy to you, we will fill out and file insurance claims for your dental services.

If you have any questions or concerns regarding your insurance coverage, we will be happy to help you contact your insurance carrier directly, regarding the specifics and details of the plan your employer has purchased on your behalf.

Signature: _____ Date:_____

TITENSOR
FAMILY, IMPLANT, COSMETIC & SEDATION DENTISTRY

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____