New Age Dental Care

Family & General Dentistry

Getting To Know Our Guest

Name:_____ Date of Birth:_____

What name do you prefer to be called?_____

Address:_____

What is the best phone number to reach you?_____

What is your e-mail address?_____

How did you find out about our office?_____

What other media do you use for finding health care services? Check all that apply.

___Direct Mail ___Coupon Mailers ___Yellow Pages ___TV ___Radio ____Newspaper
___Magazine ___Internet Search Engine ___Family and Friends ____Referral from Doctor

Where do you work?_____ Phone number:_____

Address:_____

Please share with us what you expect form us as your dental care providers.

What do you most want to achieve form your dental care?

What is the biggest concern you have about your dental health?

How would you describe your ideal smile?

How would you describe the perfect dentist?

Please rate the following in terms of importance 1=Least and 5=Most

Cost	1	2	3	4	5
Reputation	1	2	3	4	5
Takes My Insurance	1	2	3	4	5
Proximity to Home or work	1	2	3	4	5

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MEDICAL HISTORY

PATIENT NAME _____ SSN: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No _____
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Rheumatism ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Shingles ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Leukemia ○ Yes ○ No	Stroke ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Liver Disease ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Lung Disease ○ Yes ○ No	Tonsilitis ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pace Maker ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No	

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments: _____

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

NEW AGE DENTAL CARE
Family & General Dentistry
Eugenia Kardaris, D.D.S., P.C. and Associates, General Dentists

FINANCIAL AGREEMENT

Thank you for choosing us as your dental health care provider. We are committed to providing the highest quality of dental care and continued management of your oral health. Please understand that paying for your dental care is integral part of your ongoing treatment. The following is a statement of our *Financial Agreement,* which we require you to read and sign prior to any treatment. **We do offer a pre-payment discount for treatment plans that are paid in full. For patients with insurance, it is our policy to collect the patient co-pay at the time we schedule your appointment.** We accept extended payment plans through CareCredit credit approval. **There is a $25.00 charge for any returned checks.**

REGARDING DENTAL INSURANCE

All co-pays and deductibles are due on the date of service. The balance is your responsibility whether your insurance company pays or not. You are responsible for all charges incurred in this office. Your ultimate reimbursement rests with your insurance company. At New Age Dental Care, we strive for excellence in dentistry. As such, we are a mercury-free office. Insurance companies often offer an alternative benefit in paying for posterior composites. You are responsible for the difference in price of mercury containing and mercury free restorations. Please contact your individual insurance company for specifics on their compensation policy.

If your account is unpaid and forwarded to a collection agency, additional collection costs, collection fees and/or collection expenses will be incurred, the precise amount of which is difficult or impossible to know at this time. Therefore, you agree with us that upon placement with a collection agency you will pay an additional 25% of the unpaid debt after default as liquidated damages. Additionally, in the event we utilize an attorney to assist in our recovery of the debt, you agree to pay reasonable attorney fees of at least 15% of the unpaid debt after default, in addition to the debt and collection costs/fees/expenses.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or heath practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

Minor Patients/Students

The adult accompanying a minor, the parent (or guardian) are responsible for full payment. For unaccompanied minors or students, non-emergency treatment will not be provided unless the charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time of service as well as prior consent of the service to be provided to the minor.

Missed Appointments

Unless cancelled at least 24 hours in advance (business days/hours), our policy is to charge for missed appointments ($50.00 per scheduled hour). If ***emergency situations*** arise that prevents you from keeping your appointment, please let us know as soon as possible so we can reschedule your appointment. No cancellations or changes to appointments will be accepted on the answering machine. Please help us serve you better by keeping your scheduled appointment. Thank you for understanding our *Financial Agreement.* Please let us know if you have any questions or concerns.

I have read the *Financial Agreement* and understand and agree to it's terms and conditions.

Signature of Responsible Party Date

• 125 Chesterfield Business Pkwy • Chesterfield, MO 63005 • (636) 449-0216 • Fax: (636)449-1517

New Age Dental Care
Family & General Dentistry

125 Chesterfield Business Parkway
Chesterfield, MO 60005
PH: (636) 449-0215

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date: _____

We at New Age Dental Care are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please contact us at our main phone number. You may be provided with a copy upon request.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative Date

_____

Printed name of patient or patient's representative

_____

Relationship to patient