# Welcome to Aurora Dental Care!

*We strive to make your dental visits pleasant and comfortable.*
*Our goal is to teach you oral habits which will help you to achieve and keep Healthy Teeth and Gums for Life!*

Today's date: ________________________

Full Name: _____________________________________________________ Prefer to be called:__________________

Birth Date: ______________________________SS #: ________________________________________Sex: M F

Home Address: _____________________________________________________________ Zip Code: _____________

Phone #'s Home: _(_____)___________________ Cell: _(_____)________________ Work: _(____)________________

Email: ___________________________________________________________________________________________

Place of Employment: ___________________________________________ School: ____________________________

In case of emergency, please contact: _________________________________Phone #: __(____)_____________________

***How did you hear about Aurora Dental Care?*** ______________________________________________________________

**PRIMARY DENTAL INSURANCE:**

Policy Holders Name: _______________________________ Relationship to Patient: __________________________

Social Security #: __________________________________ DOB of Policy Holder: ___________________________

Employer: ______________________________________ Address_________________Ph # (____)_____________

Employer Phone #_(_____)________________________ **Group #** _______________________________(***CODE "A"***)

Employer Address: _______________________________ **Subscriber ID #** ________________________________

______________________________________________

Insurance Co : __________________________________

**Additional Dental Insurance:**

Policy Holders Name: ____________________________ Relationship to Patient: ___________________________

Social Security #: ________________________________ DOB of Policy Holder: ___________________________

Employer: ___________________________Insurance Co. Name: _____________________________________________

Insurance Co. Address: ________________________________________ Phone: _(______)________________________

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize Aurora Dental Care to release any information including the diagnosis and records of any treatment or examination rendered to my child/me during the period of such dental care to third party payers and other health care practitioners. This is necessary in order to submit your insurance claims for you and also to communicate with other dental specialist or medical providers should the need arise. A copy of the Privacy Practices is hanging in our reception area and available upon request.

I, ________________________, understand that by signing this consent form I am giving my consent to
(Please print)
Aurora Dental Care to use and disclose of myself or my child/children's protected health information to carry out treatment, payment activities and health care operations.

X ______________________________________________________ Date: ________________________

Please list the names of any person(s) with whom we may discuss matters relating to your treatment including appointments, financial and other matters relating to your treatment.

_________________________________ _____________________________ _______________________
*Name* *Phone Number* *Relationship*

## OFFICE &FINANCIAL POLICY *(IMPORTANT PLEASE READ)*

**Welcome to Aurora Dental Care**. Thank you for choosing us as your dental care providers. We are committed to providing outstanding dental care in a comfortable and relaxed environment. We use modern technology and high quality materials ensuring patients receive the best dental treatment available today. The following is a statement of our office and financial policies which we request that you read and sign prior to any dental treatment.

**Full payment for services rendered is due at the time of service** (unless prior payment arrangements have been made). We accept cash, personal checks, Visa, MasterCard, Amex, Discover and Care Credit.

**Dental Insurance:** We understand the value of your insurance benefits and will assist you in obtaining your maximum benefits. We cannot bill your insurance company unless you give us the correct information. We may accept an assignment of insurance, however you are responsible for co-pays and deductibles at the time services are rendered. We also require a credit card on file in the event of a remaining balance once insurance benefits are received.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do not receive your insurance payment in full within 45 days from the date services are rendered, the balance will be automatically billed to you for immediate payment. Our estimate of insurance payment is not a guarantee of payment by your insurance company. The final payment is determined at the time your claim is received and reviewed by your insurance company.

**Major Procedures/Treatment**: Our office offers a 5% prepay discount on services of $300 or more when payment is made by cash or check and a 3% prepay discount on services of $300 or more when payment is made by Credit Card. Care Credit or any other third party/interest free financing cannot be used with this option.

**Service Charge:** In the case of default of payment, the patient or responsible party promises to pay any legal interest on balance due, together with any collection costs and reasonable attorney fees incurred to the effect to collection of this account or future outstanding accounts.

**Missed Appointment:** We respect the value of our patient's time. Every effort will be made to accommodate each patient at their scheduled time. We recognize that at times there may be a cancel or reschedule an appointment; therefore we ask that you contact the office 24 hours in advance when you cannot keep your scheduled appointment. If you do not cancel or reschedule your appointment at least 24 hours in advance, our policy is to charged a missed appointment fee of $50. Please help us to better serve you and all our patients by keeping your scheduled appointments.

**I have read and understand the office & financial policy, and agree to these terms.**

_______________________________________________________ Date ______________________________
***Signature of Patient or Responsible Party***

## PAYMENT AUTHORIZATION

I authorize Aurora Dental Care to:

☐ Please keep this signature on file for any estimated patient portion due at the time of service.

☐ Please keep this signature on file for any estimated patient portion due at the time of service and any unpaid balance after insurance payment.

☐ Please Call me before charging my card

☐ Please send me a receipt

Name as it appears card: ________________________________________Phone # ____________________

***Please Print***

Visa MC Discov AmEx CareCred

Card # _______________________________

Exp Date: ___________________________

Billing Zip: _________________________

CVD #:______________________________

Card Holder Signature: _______________________________________________________

## INSURANCE AUTHORIZATION/PAYMENT AGREEMENT

I authorize and request my insurance company to directly pay Aurora Dental Care for claims submitted on behalf of my self/ child/children. I understand my insurance may pay less than the actual bill for services. I agree to be completely responsible for payment of all services rendered on behalf of myself/child/children.

If I do not pay the entire balance within 30 days of the monthly billing date, a late fee of 1.8% APR will be accessed each month. I realize that failure to keep this account current may result in Aurora Dental Care being unable to provide dental services except for emergency treatment. In the case of default of payment on this account, I agree to pay all collection costs and attorney fees incurred in attempting to collect this debt.

X ________________________________________________ Date: ______________________________

***Signature***

. Name

_________________________Date_____________

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

| List any medications you are taking…. | | | |
|---|---|---|---|
| | | | |
| List any daily supplements, herbs, or vitamins you take… | | | |
| Have you ever had a major operation? | Yes | No | If Yes: |
| Have you ever been told you need to be pre-medicated before any dental procedure? | Yes | No | If Yes: |
| Have you ever had a serious head or neck injury? | Yes | No | If Yes: |
| Have you ever taken Fosamax, Boniva, Actonel Or any other medications containing bisphosphonates? | Yes | No | If Yes: |
| Who Is your Primary Physician? (name and phone) | | | |

| **Are you allergic to any or the following?** | | | |
|---|---|---|---|
| Aspirin | Penicillin | Codeine | Acrylic |
| Metal | Latex | Sulfa Drugs | Local Anesthetics |
| Erythromycin | Tetracycline | Seasonal, Pet, food | Other? |

| **Women: Are you….** | | |
|---|---|---|
| Pregnant/trying to get pregnant? Yes No | Nursing? Yes No | Taking oral contraceptives? Yes No |

**Do you have any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes | No | Hemophilia | Yes | No |
| Alzheimer’s Disease | Yes | No | Hepatitis A | Yes | No |
| Anaphylaxis | Yes | No | Hepatitis B or C | Yes | No |
| Anemia | Yes | No | Herpes | Yes | No |
| Angina | Yes | No | High Blood Pressure | Yes | No |
| Arthritis/Gout | Yes | No | High Cholesterol | Yes | No |
| Artificial Heart Valve | Yes | No | Hives or Rash | Yes | No |
| Artificial Joint | Yes | No | Hypoglycemia | Yes | No |
| Asthma | Yes | No | Irregular Heartbeat | Yes | No |
| Blood Disease | Yes | No | Kidney Problems | Yes | No |
| Blood Transfusion | Yes | No | Leukemia | Yes | No |
| Breathing Problems | Yes | No | Liver Disease | Yes | No |
| Bruise Easily | Yes | No | Low Blood Pressure | Yes | No |
| Cancer | Yes | No | Lung DiseaseMitro Valve Prolapse | Yes | No |
| Chemotherapy | Yes | No | Osteoporosis | Yes | No |
| Chest Pains | Yes | No | Pain In Jaw Joints | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Parathyroid Disease | Yes | No |
| Congenital Heart Disorder | Yes | No | Psychiatric Care | Yes | No |
| Convulsions | Yes | No | Pace Maker | Yes | No |
| Cortisone Medicine | Yes | No | Radiation Treatments | Yes | No |
| Diabetes | Yes | No | Recent Weight Loss | Yes | No |
| Drug Addiction | Yes | No | Renal Dialysis | Yes | No |
| Easily Winded | Yes | No | Rheumatic Fever | Yes | No |

| | | | | | |
|---|---|---|---|---|---|
| Emphysema | Yes | No | Rheumatism | Yes | No |
| Epilepsy or Seizures | Yes | No | Scarlet Fever | Yes | No |
| Excessive Bleeding | Yes | No | Shingles | Yes | No |
| Excessive Thirst | Yes | No | Sickle Cell Disease | Yes | No |
| Fainting Spells/Dizziness | Yes | No | Sinus Trouble | Yes | No |
| Frequent Cough | Yes | No | Spina Bifida | Yes | No |
| Frequent Diarrhea | Yes | No | Stomach/Intestinal Disease | Yes | No |
| Frequent Headaches | Yes | No | Stroke | Yes | No |
| Genital Herpes | Yes | No | Swelling of Limbs | Yes | No |
| Glaucoma | Yes | No | Thyroid Disease | Yes | No |
| Hay Fever | Yes | No | Tonsillitis | Yes | No |
| Heart Attack/Failure | Yes | No | Tuberculosis | Yes | No |
| Heart Murmur | Yes | No | Tumors or Growths | Yes | No |
| Heart Pacemaker | Yes | No | Ulcers | Yes | No |
| Heart Trouble/Disease | Yes | No | Venereal Disease | Yes | No |
| Heart Trouble/Disease | Yes | No | | | |
| Have you ever had a serious illness not listed? | Yes | No | If yes: | | |

Over>>

| **Dental History** | | | |
|---|---|---|---|
| Are you currently in pain? | Yes | No | |
| Do you brush daily? | Yes | No | |
| Do you floss daily? | Yes | No | |
| Do your gums ever bleed? | Yes | No | |
| Have you ever had periodontal disease?(gum disease) | Yes | No | |
| Have you experienced problems associated with any previous dental work? | Yes | No | |
| Do you now or have you ever experienced pain/ discomfort in your jaw point? | Yes | No | If yes when: |
| Who was your previous Dentist? | | | |
| Why did you leave your Dentist? | | | |
| Are you happy with the way your smile looks? | Yes | No | If no what would you change? |
| Do you smoke or chew tobacco? (present or past) | Yes | No | |

| | |
|---|---|
| Who can we thank for referring you today | |
| What is most important to your about your teeth? | Circle all that apply: Function Health Looks |
| What would be your chief complaint about your smile today? | |
| What problem would you MOST like to address? | |
| | |

| Would you be interested in: | |
|---|---|
| Cosmetic Dentistry? | Yes No |
| Porcelain Veneers? | Yes No |
| Straightening your Teeth? | Yes No |
| Can I speak to you about Invisalign? | Yes No |
| Whitening your teeth? | Yes No |

**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 or Guardian X___________________________________________________________________________