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_____