Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Pillsbury Dental Associates
125 Greentree Dr., Dover, Delaware 19904
www.Pillsburydentalassociates.com
(302) 734-0330
FAX (302) 674-8218

*SS#/SIN*_____

Patient Information (CONFIDENTIAL)

*Date*_____

*Name*_____*Birthdate*_____*Home Phone*_____
*Address*_____*City*_____*State*_____*Zip*_____
*Email*_____*Cell Phone*_____
Check Appropriate Box ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*
*If Student, Name of School/College*_____*City*_____*State*_____ ☐ *Full Time* ☐ *Part Time*
*Patient or Parent/Guardian's Employer*_____*Work Phone*_____
*Business Address*_____*City*_____*State*_____*Zip*_____
*Spouse or Parents/Guardian's Name*_____*Employer*_____*Work Phone*_____
*Whom may we thank for referring you?*_____
*Person to contact in case of emergency*_____*Phone*_____

Responsible Party

*Name of Person Responsible for this Account*_____*Relationship to Patient*_____
*Address*_____*Home Phone*_____
*Email*_____*Cell Phone*_____
*Driver's License#*_____*Birthdate*_____*Financial Institution*_____
*Employer*_____*Work Phone*_____*SS#/SIN*_____
Is this person currently a patient in our office? ☐ *Yes* ☐ *No*
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. ☐ *Cash* ☐ *Personal Check* *Credit Card* ☐ *Visa* ☐ *MasterCard* ☐ *I want to discuss the office's payment policy.*

Insurance Information

*Name of Insured*_____*Relationship to Patient*_____
*Birthdate*_____*SS#/SIN*_____*Date Employed*_____
*Name of Employer*_____*Union or Local*_____*Work Phone*_____
*Address of Employer*_____*City*_____*State*_____*Zip*_____
*Insurance Company*_____*Group#*_____*Policy/ID#*_____
*Ins. Co. Address*_____*City*_____*State*_____*Zip*_____
*How much is your deductible?*_____*How much have you used?*_____*Max. annual benefit*_____
DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No IF YES, COMPLETE THE FOLLOWING*
*Name of Insured*_____*Relationship to Pateient*_____
*Birthdate*_____*SS#/SIN*_____*Date Employed*_____
*Name of Employer*_____*Union or Local*_____*Work Phone*_____
*Address of Employer*_____*City*_____*State*_____*Zip*_____
*Insurance Company*_____*Group#*_____*Policy/ID#*_____
*Ins. Co. Address*_____*City*_____*State*_____*Zip*_____
*How much is your deductible?*_____*How much have you used?*_____*Max. annual benefit*_____

OVER PLEASE

Patient Medical History

Physician_____Office Phone_____Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?.....	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain_____ _____	☐	☐
3. Are you taking medication(s) Including non-prescription medicine?..... If yes, what medication(s) are you taking?_____ _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?.....	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?.....	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra In the last 24 hours?.....	☐	☐
7. Do you use tobacco?.....	☐	☐
8. Do you use controlled substances?.....	☐	☐

	Yes	No
10. Are you wearing contact lenses?.....	☐	☐
11. Are you allergic to or have had any reactions to the following?		
Local Anethetics (e.g. Novocain).....	☐	☐
Penicillin or any other Antibiotics.....	☐	☐
Sulfa Drugs.....	☐	☐
Barbiturates.....	☐	☐
Sedatives.....	☐	☐
Iodine.....	☐	☐
Aspirin.....	☐	☐
Any Metals (e.g. nickel,mercury,etc.).....	☐	☐
Latex Rubber?.....	☐	☐
Other(please list)_____		
12. Do you have a persistent cough or throat clearing not associated with a known illness(lasting more Thank 3 weeks)?.....	☐	☐
13. Women Only:		
a.) Are you pregnant or think you may be pregnant?.....	☐	☐
b.) Are you nursing?.....	☐	☐
c.) Are you taking oral contraceptives?....	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	☐	☐	Heart Disease.....	☐	☐	Chest Pains.....	☐	☐
Heart Attack.....	☐	☐	Cardiac Pacemaker.....	☐	☐	Easily Winded.....	☐	☐
Rheumatic Fever.....	☐	☐	Heart Murmur.....	☐	☐	Stroke.....	☐	☐
Swollen Ankles.....	☐	☐	Angina.....	☐	☐	Hay Fever/Allergies....	☐	☐
Fainting/Seizures.....	☐	☐	Frequently Tired.....	☐	☐	Tuberculosis.....	☐	☐
Asthma.....	☐	☐	Anemia.....	☐	☐	Radiation Therapy.....	☐	☐
Low Blood Pressure.....	☐	☐	Emphysema.....	☐	☐	Glaucoma.....	☐	☐
Epilepsy/Convulsions.....	☐	☐	Cancer.....	☐	☐	Recent Weight Loss.....	☐	☐
Leukemia.....	☐	☐	Arthritis.....	☐	☐	Liver Disease.....	☐	☐
Diabetes.....	☐	☐	Joint Replacement.....	☐	☐	Heart Trouble.....	☐	☐
Kidney Disease.....	☐	☐	Hepatitis/Jaundice.....	☐	☐	Respiratory Problems...	☐	☐
AIDS or HIV Infection.....	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse...	☐	☐
Thyroid Problem.....	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other_____	☐	☐

Patient Dental History

Name of Previous Dentist and Location_____Date of Last Exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?.....	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?.....	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?.....	☐	☐
4. Do you feel pain to any of your teeth?.....	☐	☐
5. Do you have any sores or lumps in or near your mouth?.....	☐	☐
6. Have you had any head, neck or jaw injuries?.....	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking.....	☐	☐
Pain (joint, ear, side of face).....	☐	☐
Difficulty in opening and closing.....	☐	☐
Difficulty in chewing.....	☐	☐

	Yes	No
8. Do you have frequent headaches?.....	☐	☐
9. Do you clench or grind your teeth?.....	☐	☐
10. Do you bite your lips or cheeks frequently?.....	☐	☐
11. Have you ever had any difficult extractions in the past?.....	☐	☐
12. Have you ever had any prolonged bleeding following extractions?.....	☐	☐
13. Have you had orthodontic treatment?.....	☐	☐
14. Do you wear dentures or partials?.....	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	☐	☐
16. Do you like your smile?.....	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnoses and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*X*_____

Signature of patient (or parent/guardian if minor) *Date*

*Doctor's Comments*_____

_____

_____

_____

_____

_____*Signature*_____*Date*_____

Mission Statement

Pillsbury Dental Associates

Mission: Healthy, attractive mouths and ideal quality of life for our patients- This includes healthy teeth and gums and supporting bone for the teeth. The mouth is an integral part of the body, and a person cannot be truly healthy without a healthy mouth. Many serious systemic diseases can be worsened by an unhealthy mouth. Things we do to achieve a healthy mouth:

1. Treat and eliminate tooth decay.
2. Prevent tooth decay.
3. Cleaning procedures to treat and prevent gum and bone disease around the teeth.
4. Treat abscessed teeth which can be dangerous and even life threatening.
5. Strengthen broken or weakened teeth to prevent them from fracturing and being lost.
6. Remove diseased, non-repairable teeth from the mouth.
7. Replace missing teeth to prevent future loss of other teeth, enhance appearance, maintain tooth position, and restore function.
8. Examine and treat soft tissues of the mouth and face and check for cancer or other disease.
9. Provide healthy, attractive smiles.
10. Perform regular checkup examinations to assure that health is maintained.
11. Treat jaw joint, muscle, and bite problems.

In the final analysis, teeth are quality of life.

Pillsbury Dental Associates

Appointments and Finances

Everyone benefits when there is a clear understanding of our treatment and financial policies prior to treatment. They are intended to be fair to all of our patients and help control administrative costs.

Appointments

Please be on time for your scheduled appointments. We have exclusively reserved the doctor, staff, and facility for your personal dental care. In the event you must cancel or reschedule, we would appreciate your giving us 48 business hours notice so that we may effectively re-utilize the time with the doctor or hygienist. If you do not show up for an appointment you made, we could charge you a reactivation fee of $100.00 plus an appointment reservation fee, as explained below. The reactivation fee must be paid prior to making another appointment. We will not apply this policy indiscriminately but will consider patient longevity with the practice and previous history of reliability.

We now require reservation or retainer fees in order to make an appointment. Patients having dental insurance are required to pay their co pay for treatment planned for the next appointment. Patients without insurance are required to pay 30% of planned treatment for the next appointment. These pre-treatment fees are applied to work completed at the next appointment. Patients, while observing these minimums, always have the option of paying in full on treatment plans or paying ahead. For treatment plans over $1,000.00, we will consider a discount. Patients paying in full may receive a 5% discount..

Fees

Fees for quality dental treatment are based on the type of treatment and the time needed to complete the treatment. Our office believes that our fees are a fair representation of the standard of care and in-step with the industry standard.

Payments

Payment is due at the time of service. A treatment plan will be developed and an estimate of your total fee will be presented to you. We accept cash, checks, and major credit cards. We offer extended payment plans, some of which are interest-free, for those who qualify.

Insurance

As a convenience to our patients, we will bill your insurance company for treatment rendered, provided we have current benefit coverage information. Please understand that your dental benefit program is a contract between you, your employer, and the insurance company. We do not have a contract with your insurance company and therefore have to hold you responsible for any balance on your account. If your insurance company does not make a payment within 45 days, you will be notified. If a payment is not made within 60 days, we will bill you for any outstanding balance. In this case, we will help you get reimbursement directly from the insurance company.

Our office thanks you for your time, cooperation and trust in us to deliver comfortable, safe and quality dental care to you, your family and friends. We also appreciate your understanding of the necessity for the above guidelines.

I have read, understand and will abide by the above procedures.

_____ _____

Responsible Party Signature Date

Pillsbury Dental Associates

A Word

About

Dental Insurance

We accept dental insurance as a form of payment. Insurance is a welcome help, but it seldom covers the total cost of all necessary dental care within one insurance maximum cycle. Patients often delay or forego needed treatment because of inadequate insurance coverage. Untreated conditions become worse: gum disease progresses and teeth continue to decay leading to pain, infection, and eventual tooth loss. Poor oral health has serious effects on the rest of the body. Conditions like diabetes and cardiovascular disease are glaring examples of diseases made worse by an unhealthy mouth. Chronically abscessed, non-painful teeth can flare up unexpectedly and even develop into dangerous, life-threatening situations.

Dental insurance is not designed to cover everything you need to give you a healthy mouth. We offer programs such as Springstone and Care Credit to help you afford the care you need. These are programs offering no- interest or interest-bearing, payment plan formats. Please ask our business staff about these programs. We also accept credit cards, checks and cash. Once your active treatment is completed, periodic checkups and hygiene visits are vital for your continued health. Checkups and hygiene visits are of minimal expense and covered by dental insurance.

Pillsbury Dental Associates

125 Greentree Drive

Suite 2

Dover, De 19904

(302) 734-0330

FAX (302) 674-8281

Collections and Outstanding Balance Policy

- A $10.00 monthly billing/administrative charge will be added to any account requiring a mailed statement. Please be prepared to pay co-pay at the time of service.
- Any outstanding balance after 60 days from the date of service is subject to a 1.5% per month finance charge. This applies only to the patients with dental insurance.
- Any outstanding balance after 90 days from the date of service may be referred to an outside collection agency.
- Accounts referred to an outstanding collection agency or attorney may be subject to a collection agency fee of 33% or higher. This will be added to the total balance due.
- Patients with delinquent accounts or accounts sent to collections may be discharged from our practice.
- Returned check fee is $35.00
- Records transfer fee is $25.00 and is payable by the patient

Pillsbury Dental Associates

HIPAA AUTHORIZATION FORM

I, _____ , hereby authorize the use or disclosure of my protected Health information, medical records, account information and any other information regarding my dental health to the following persons:

Name: _____

DOB: _____

Name: _____

DOB: _____

Pillsbury Dental Associates

ACKNOWLEDMENT OF RECIEPT
HIPPA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

_____

Patient Name (Please Print)

_____ _____

Patient Signature **Date**

OR

_____

Signature of Personal Representative

Authority of Personal Representative to sign for Patient (check one)

- **Parent**
- **Guardian'**
- **Power of Attorney** _____

The front desk has a copy of the HIPAA Notice of Privacy if you would like to obtain a copy.

- **Please Note: It is your right to refuse to sign this Acknowledgement**

Dental Office Use Only

I tried to obtain written Acknowledgment by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

__ an emergency prevented us from obtaining the acknowledgement.

__ a communication barrier prevented us from obtaing acknowledgement.

__ the individual was unwilling to sign.

__ Other: _____

_____ _____

Staff Member Signature **Date**

Informed Consent

For

Local Anesthesia (Injections)

The advantage of local anesthesia (shots, needles) is pain-free dental treatment. We emphasize that complications from local anesthesia are extremely rare, but complications can and do occur and may include but are not necessarily limited to the following:

1. Needle Tract soreness in soft tissues, usually does not last for more than 24 hrs.
2. Hematoma, swelling or bruising of the facial soft tissues, usually resolves by itself with no permanent effects.
3. Partial or Total numbness, may or may not resolve.
4. Pain upon biting on a tooth, this can occur with intra-ligamentary injections which are given right beside the tooth to be anesthetized. This normally resolves in a few days but can take longer to resolve.

We emphasize that pain-free dental treatment cannot be provided without local anesthesia and that complications from local anesthesia are extremely rare. This is a routine procedure.

I have read and understand the above and give my consent for local anesthesia. All my questions have been answered.

_____

Patient/Parent/Guardian Signature Date:_____

Pillsbury Dental Associates
125-2 Greentree Dr.
Dover, DE 19904
(302) 734-0330
www.Pillsburydentalassociates.com

Authorization to take Photographs

I hereby authorize photographs to be taken in connection with my dental treatment.

I understand that photographs will be used to more thoroughly document my case, to assist in diagnosis and treatment planning, to document need for certain types of treatment to insurance carriers, and for promotional/advertising and educational purposes.

Please initial the appropriate box below:

__ I authorize intraoral (mouth and teeth) photos only.

__ I authorize full face photos as well as intraoral photos.

Patient Signature:_____ Date:_____