Pine Ridge Dental
5140 S. 56th St. Lincoln, NE 68516 ● 8545 Executive Woods Dr. Lincoln, NE 68512
Phone: 402.423.1100 ● Fax: 402.423.1368 ● www.pineridgedental.com
The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.
Please fill out these forms completely. The better we communicate, the better we can care for you.

Patient name:____ Today's Date:______________________

Name preference:____ ☐ Male ☐ Female

Referred to Pine Ridge Dental through:__________________________________

Birthdate:_______________________ Age:_____________________________ SSN:______________________________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please Check preferred mode(s) of contact:

☐ Cell Phone:___________________ ☐ Home Phone:___________________ ☐ Work phone:____________________
☐ Call ☐ Text May we call you at work? ☐Yes ☐No

☐ E-mail:____

Home Address:____
Street City State Zip

Employer: ____ Occupation: ______________________

Person financially Responsible, if not self: _______________________________ Relationship: _______________________

Billing Address: ____
Street City State Zip

Emergency Contact:_________________________ Relationship:_________________ Phone:______________________

Medical Information

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ____

____

Physician Name:__________________ Phone: _________________

Date of last physical exam:___________________________________

Are you currently taking any medications?

☐ Yes ☐ No If yes, please list or attach on a separate sheet

____

____

____

Are you presently taking, or have you ever taken any of the following bisphosphonates drugs to treat bone disorders including osteoporosis?

☐Actonel (risedronate)
☐Aredia (pamidronate)
☐Didronel (etidronate)
☐Fosamax (alendronate)
☐Skelid (tiludronate disodium)
☐Zometa/Reclast (zoledronate)
☐Boniva (ibandronate)

For women, are you pregnant? ☐ Possibly ☐ Yes ☐ No If yes, week#: _

Do you need to be pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No What is the Pre-Med for?________________

Have you had serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? ☐ Yes ☐ No

If yes please explain ___________________________________

____

Check box if you have had any history of or conditions related to, any of the following:

☐ Anemia
☐ Arthritis
☐ Asthma/Respiratory problems
☐ Atrial Fibrillation
☐ Chronic sinus problems
☐ Cancer/Tumors
☐ Congenital heart disease
☐ Chronic Hepatitis
☐ Chemo/Radiation
☐ Diabetes
☐ Drug/Alcohol abuse
☐ Dental Anxiety
☐ Epilepsy/Seizures
☐ Fainting spells
☐ Fever blister/cold sores
☐ Fibromyalgia
☐ Hearing problems
☐ Heart attack
☐ Heart surgery
☐ Heart valve Disease
☐ Hemophilia /bleeding
☐ HIV+/AIDS
☐ High Blood Pressure
☐ Human papilloma virus
☐ Hyperthyroid Hypothyroid
☐ Infective endocarditis
☐ Joint replacement
☐ Kidney disease
☐ Liver disease
☐ Low blood pressure
☐ Pacemaker
☐ Prosthetic heart valve
☐ Psychiatric disorders
☐ Shingles
☐ Sickle cell disease
☐ Sight problems
☐ Stroke
☐ TMJ/Jaw pain/TMD
☐ Tobacco use, how much?__
☐ Transplant
☐ Tuberculosis
☐ NONE

Have you experienced any other serious conditions that are not listed above? ☐ Yes ☐ No If yes, please list: _________________________

____

Allergies:

☐Penicillin/Amoxicillin
☐Aspirin
☐Sulfa drugs
☐jewelry/Nickel
☐Erythromycin
☐Tetracycline
☐Cephalosporins
☐Latex (rubber)
☐Sulfur drugs
☐Dental anesthetics
☐Codeine
☐Clindamycin
☐Other, please list

____

____

Dental Information

Why have you come to the dentist today?

____

____

Date of your last dental visit: ______________________________

When were your teeth last cleaned: ___________________________

Do you have your wisdom teeth? ☐ Yes ☐ No ☐ Don't Know

Are you currently experiencing dental pain? ☐ Yes ☐ No

____

Do you experience dental anxiety? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

If no, what would you like to change? ___________________________

Have you had complication or difficulties with previous dental treatment? ☐ Yes ☐ No

If yes please explain: ____________________________________

____

____

If you have dental insurance, do you let the insurance dictate what treatment you should receive? ☐ Yes ☐ No

Do you have suggestions on how Pine Ridge Dental can best meet your needs? ☐ Yes ☐ No

If yes please explain: ____________________________________

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

Patient signature:_____________________ Date:____________

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY Doctor's Comments:

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Insurance, Financial Options, and Appointment Agreement

Patient Name:	Date of Birth:

Dental Insurance

As a courtesy, we will process insurance for you. All questions regarding your insurance coverage must be addressed by you with your insurance company. **We will try to help you understand your insurance coverage, but ultimately it is your responsibility to know the details of your plan**. Insurance companies never guarantee benefits.

Dental insurance is a contract between the employer and the patient. For example, Amalgam verses Composite for fillings. The extent of coverage varies greatly between plans and sometimes even within a single plan. We will always recommend optimal treatment according to our standard of care regardless of insurance coverage. *(Initial)* _______

Any balance not covered by your dental insurance is your responsibility. The estimated portion will be due at the time of treatment, unless prior arrangements have been made. Should our estimation be too high, a refund will be made. Likewise, if the estimate was too low, the remainder will be your responsibility. *(Initial)* _______

Primary Insurance Coverage

Policy Holder: ____
Employer: ____
Insurance Company: ____
Claims Address: ____
City, State, Zip: ____
Phone: _____________________ Group #: ___________________
Policy Holder ID #: ____________ Date of Birth: _______________

Secondary Insurance Coverage

Policy Holder: ____
Employer: ____
Insurance Company: ____
Claims Address: ____
City, State, Zip: ____
Phone: _____________________ Group #: ___________________
Policy Holder ID #: ____________ Date of Birth: _______________

Financial Options

- We are committed to supporting you in understanding your dental health, and will always present you with the best dental options possible to address your personal health situation. To make these services comfortably affordable, we are pleased to offer you the following payment options:
- Patients **without insurance** coverage can receive one of the following:
  - 5% discount when services are **paid in full with cash or check the day of treatment**
  - 10% discount for senior citizens and military personnel
  - Patients also have the opportunity to utilize our “On Call Club” discount for recall appointments.
- Visa, MasterCard, Discover, Cash, Check
- No interest payment plans with *CareCredit* up to 12 months

I agree that I am fully responsible for the total amount of all procedures performed at Pine Ridge Dental. I understand that all payments are due within 60 days of the date of service. I understand that at 60 days my account will accrue interest 16% annually and balances over 90 days are subject to collection activity. *(Initial)* _______

Appointment Agreement

We value your time and reserve a set amount of time in our schedule to ensure you receive quality care. Should you need to cancel or change your appointment, **we ask for a 24-hour notice. Otherwise, you could be subject to a $35 broken appointment fee.** Our goal is that you have an outstanding experience at Pine Ridge Dental. If you have additional questions, please speak to one of our administrative team members for further information.

_______________________________________ _______________________________
Patient / Parent / Legal Guardian Signature Date

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Patient Acknowledgment of Receipt of Notice of Privacy Practices

HIPAA Authorization

I hereby acknowledge that I have reviewed and received a copy of Pine Ridge Dental's *Notice of Privacy Practices* explaining:

- How Pine Ridge Dental will use and disclose my protected health information,
- My privacy rights with regard to my protected health information, and
- Pine Ridge Dental's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or concerns, I may contact Colene at 402-423-1100 or colene@pineridgedental.com.

I may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Their contact information can be found at www.hhs.gov/about/contactus/index.html.

I hereby give authorization to the following people to access my personal health information:

_______________ _______________ _______________

Consent for Communications

I give consent to the dental practice to use my cell phone number regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell phone is (   ) ______________________. I consent to *(Choose one or both):* ☐ Call ☐ Text

I give consent to receiving emails from the dental practice regarding treatment, insurance, special promotions, and my account. I understand I can withdraw my consent at any time.

My email address is ______________________________________.

______________________________ ______________________________

Patient / Parent / Legal Guardian Signature Date

FOR OFFICE USE ONLY

We made a good-faith effort to obtain an acknowledgment of ___________'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ______________________
☐ Communication barriers prohibited obtaining an acknowledgment
☐ An emergency situation prevented us from obtaining an acknowledgment
☐ Other ____

Attempt was made by: ______________________________ Date: ______________________