THE CANTON DENTAL COLLABORATIVE

Name of Patient _____ (If a child, name of supporting parent) _____

Address _____ Telephone# _____ Name of Spouse _____

City or Town _____ State _____ Zip _____

Birthdate: _____ Age: _____

Patient's Social Security # (If a child, supporting parent's S.S. #) _____

Patient (or supporting parent) employer's name and address _____ Telephone# _____

Present Position _____ How Long? _____ Spouses Employer _____ How Long? _____

Name of Primary Dental Insurance Co. _____ Policy# _____ Name of Policyholder _____

Name of Secondary Dental Insurance Co. (If applicable) _____ Name of Policyholder _____

How did you hear about us?

Are any other family members patients of our office? ☐Yes ☐No

Patients with dental insurance should complete the following for our records:

DENTAL INSURANCE

ASSIGNMENT OF BENEFITS:

I authorize payment of dental benefits to the named provider for professional services rendered.

Signed (Subscriber) _____ Date

RELEASE OF INFORMATION:

I authorize the release of any dental information necessary to process this claim.

Signed (Patient, or parent if minor) _____ Date

RECORD

It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. Information given is strictly confidential and will not be released to anyone without your written permission.

Why are you now seeking dental treatment? _____

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,

1. Are you under a physician's care now? If yes, why?
2. Have you ever been hospitalized or had a major operation?
3. Have you ever had serious head or neck injury?
4. Are you taking any medications, pills, or drugs? List?
5. Do you take, or have you taken, Phen-Fen or Redux?
6. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonate?
7. Are you on a special diet?
8. Do you use tobacco?
9. Do you use controlled substance?
10. Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other: _____

Women:

☐ Are you pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatment	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug addiction	Yes	No	Hepatitis B/C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Fainting/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spine Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach Disease	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling Of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Blisters	Yes	No	Heart Murmur	Yes	No	Pain In Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcer	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice	Yes	No									

Have you ever had any serious illness not listed above? Yes No If yes_____

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

X Signature of Patient, Parent or Guardian:

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

The Canton Dental Collaborative
Payment Policy

In an effort to keep our costs at a minimum, we have a "Non-Billing" policy at The Canton Dental Collaborative.

Please feel free to contact our office at any time to discuss your treatment and its cost.

Cash Patients

**Payment is expected at the time services are rendered.

••We accept cash, checks, and all major credit cards.

**There will be a $35 charge for any returned

check

Insurance Patients

**The patient must provide updated insurance information at the time of visits.

**The patient must complete the patient's information portion and sign the Insurance form before submitting it to our business office.

**The patient is responsible for the insurance deductibles as well as any fees not covered by the Insurance plan at the time services are rendered.

**The patient Is responsible for informing the business office of any insurance changes before the date of service.

Cancellation Policy

A scheduled appointment is a contract between you and your dentist. There is a $50/HR charge to the patient for any missed appointment or any appointment cancelled in less than 24 hours of the scheduled time of appointment.

Authorization

I agree to abide by the cancellation policy of the office.

I am aware that I must follow and take responsibility for the guidelines established by my insurance carrier, which may include waiting periods, time limitations, deductibles, preferred programs and maximum. I am also aware that I am responsible for payment of uncovered charges.

I understand and agree to pay 1.5% per month finance charges on balances 30 days overdue.

_____

Signature

THE CANTON DENTAL COLLABORATIVE

PATIENT CONSENT FORM

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

*We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.

*We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

*We may need to use your health Information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign the consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment. Please feel free to ask for a copy.

Your Right To Limit Uses or Disclosures

You have the right to request that we do not disclose your health Information to specific Individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction Is binding on us.

Your Right To Revoke Your Authorization·

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to the terms. I am also acknowledging that I have received a copy of this notice.

_____	_____
Print Name	Authorized Representative
_____	_____
Signature	Date