WELCOME

Thank You for Selecting English Dental

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us—we are happy to help.

1 PATIENT INFORMATION (CONFIDENTIAL)

Name First ____________________ Middle _______________ Last __________________________ Preferred ______________

Address ____ City ____________________ State _______ Zip _____________

SSN _______________________________ Birthdate _________________________ Cell Phone __________________________

Email ____ Home Phone _________________________

Employer ____ Work Phone __________________________

Check Appropriate Option _____ Minor _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed

Person to Contact in Case of Emergency
Name _________________________________ Relationship ___________________ Phone Number ______________________

Whom May We Thank for Referring You? ____

2 RESPONSIBLE PARTY

If other than the patient, complete this section.

First Name ____ Last Name ____

Address ____ City ____________________ State ___________ Zip __________

Phone Numbers – Cell _________________________ Home ________________________ Work _________________________

Employer ____ SSN __________________________ Birthdate__________________

Payment is expected when treatment is performed, this includes patient's portion not covered by insurance. For your convenience, we offer the following methods of payment: cash, check, Visa, Mastercard, American Express, and Discover. Upon approval, our in-office payment plan of 2 equal, automatic monthly payments, Cherry, or CareCredit are available. Any balances that are 60 days past due treatment date will be subject to a $2.50 billing fee for each month thereafter until paid in full. Any accounts placed with collections are subject to additional collections costs and reasonable attorney fees incurred in attempting to collect outstanding balances.

Signature ____ Date __________________________

3 DENTAL INSURANCE INFORMATION

Insurance Co. Name ____ Group Number _____________________________

Policy Holder Name ____ Birthdate _________________________

Policy Holder SSN ______________________________________ ID Number ____

Policy Holder's Employer ____

We will gladly process your insurance claim; estimate your deductible and the portion of the fees that will be your responsibility. A portion of the estimated amount not covered by your insurance is due at the time of treatment. Our estimates are subject to final approval by your insurance company; therefore, the amount due is subject to change.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to 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 dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature ____Date ___________________________

ENGLISH DENTAL

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.

4 PATIENT MEDICAL HISTORY

Question					
Are you under a physician's care now?	☐	Yes	☐	No	Physician's Name ____________
Have you ever had major surgery?	☐	Yes	☐	No	If yes, please list ____________
Have you ever had a serious head or neck injury?	☐	Yes	☐	No	If yes, please explain____________
Are you taking any medications, pills, or drugs?	☐	Yes	☐	No	If yes, please list ____________
Do you take, or have you taken, Phen-Fen or Redux?	☐	Yes	☐	No	____________
Are you on a special diet?	☐	Yes	☐	No	____________
Do you use tobacco?	☐	Yes	☐	No	If yes, what frequency? ____________
Do you drink alcohol?	☐	Yes	☐	No	If yes, what Frequency? ____________
Do you use control substances?	☐	Yes	☐	No	If yes, what frequency? ____________

Are you allergic to any of the following?

____ Aspirin _____ Penicillin ____ Codeine ____ Acrylic ____ Any Metals ____ Latex/Rubber ____ Local Anesthetic ____ Other If yes, please explain ____________

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

	AIDS/HIV Positive		Chest Pains		Frequent Headaches		Kidney Problems		Rheumatism
	Alzheimer's Disease		Cold Sores		Genital Herpes		Leukemia		Scarlet Fever
	Anaphylaxis		Congenital Heart Disorder		Glaucoma		Liver Disease		Shingles
	Anemia		Convulsions		Heart Attack/Failure		Low Blood Pressure		Sickle Cell Disease
	Angina		Cortisone Medicine		Heart Murmur		Lung Disease		Sexually Transmitted Disease
	Arthritis/Gout		Diabetes		Heart Pace Maker		Mitral Valve Prolapse		Stomach/Intestinal Disease
	Artificial Heart Valve		Drug Addition		Heart Trouble/Disease		Osteoporosis		Stroke
	Artificial Joint		Easily Winded		Headaches/Migraines		Pain in Jaw Joints		Swelling of Limbs
	Asthma		Emphysema		Hemophilia		Parathyroid Disease		Thyroid Disease
	Blood Disease		Epilepsy or Seizures		Hepatitis A B or C		Pacemaker		Tonsillitis
	Blood Transfusion		Excessive Bleeding		Herpes		Herpes		Tuberculosis
	Breathing Problem		Excessive Thirst		High Cholesterol		Radiation Treatment		Tumor or Growths
	Bruise Easily		Fainting Spells/Dizziness		High Blood Pressure		Recent Weight Loss		Ulcers
	Cancer		Frequent Cough		Hypoglycemia		Renal Dialysis		Venereal Disease
	Chemotherapy		Frequent Diarrhea		Irregular Heartbeat		Rheumatic Fever		Yellow Jaundice

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

If yes, please explain ____________

WOMEN ONLY

Are you pregnant or trying to get pregnant?		Yes		No
Nursing?		Yes		No
Taking Oral Contraceptives?		Yes		No
Have you ever taken medication for osteoporosis or osteopenia?		Yes		No
If yes, do you still take it?		Yes		No

If yes, what Rx do you take? ____________

If no, what did you take, and for how long? ____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature ____________ Date ____________

5 PATIENT DENTAL HISTORY

Name of Previous Dentist & Location ____

Date of Last Exam ______________________

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?			Do you have frequent headaches?		
Are your teeth sensitive to hot or cold liquids/floods?			Do you clench or grind your teeth?		
Are your teeth sensitive to sweet or sour liquids/floods?			Do you bite your lips or cheeks frequently?		
Do you feel pain to any of your teeth?			Have you ever had any difficult extractions in the past?		
Do you have any sores or lumps in or near your mouth?			Have you ever had any prolonged bleeding following extractions?		
Have you had any head, neck, or jaw injuries?			Have you had any orthodontic treatment?		
Have you ever experienced any of the following problems in your jaw?			Do you wear dentures or partials?		
Clicking			If yes, date of placement ____________________		
Pain (joint, ear, side of face)			Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
Difficulty in opening or closing					
Difficulty in chewing			Do you like your smile?		

6 ORAL CANCER SCREENING

Age is the primary risk factor for oral cancer. Tobacco and alcohol also can increase incidence of oral cancer.

Identify your risk group from the following:

Increased Risk: Patients ages 18-39, younger if sexually active due to HPV exposure
High Risk: patients age 40 and older; tobacco users (any age, any type with 10 years)
Highest Risk: Patients age 40 and older who use tobacco and/or alcohol, previous history of oral cancer

Do you use tobacco? ____ Yes ____ No With what frequency? ______________________________

Do you drink alcohol? ____ Yes ____ No With what frequency? ______________________________

The oral cancer pre-screening is in addition to your regular oral exam, and takes just a few extra minutes. When the exam is performed the clinician will have you rinse with a solution, then Dr. English will check for any suspicious areas at their earliest stages.

Please indicate whether or not you wish to have the oral cancer pre-screening by checking the appropriate option below:

____ Yes I wish to have an oral cancer pre-screening

____ No I would prefer not to have an oral cancer pre-screening

7 SLEEP APNEA SCREENING

Question		
Have you ever been told you stop breathing while asleep?	☐ Yes	☐ No
Have you ever fallen asleep or nodded off while driving?	☐ Yes	☐ No
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	☐ Yes	☐ No
Do you feel excessively sleepy during the day?	☐ Yes	☐ No
Do you snore or have you ever been told you snore?	☐ Yes	☐ No
Have you had weight gain or found it difficult to lose?	☐ Yes	☐ No
Have you taken medication for, or been diagnosed with, high blood pressure?	☐ Yes	☐ No
Do you kick or jerk your legs while sleeping?	☐ Yes	☐ No
Do you feel burning, tingling, or crawling sensations in your legs when you wake up?	☐ Yes	☐ No
Do you wake up with headaches during the night or in the morning?	☐ Yes	☐ No
Do you have trouble falling asleep?	☐ Yes	☐ No
Do you have trouble staying asleep once you fall asleep?	☐ Yes	☐ No

CONSENT TO PERFORM DENTISTRY

I,____ , hereby consent to and authorize Dr. Nicholas English, and/or his dental affiliates and assigns, to provide and perform any or all of the following dental treatment procedures, including oral surgery, in conjunction with the use of any necessary or advisable radiograph and other diagnostic aids as he deems useful

1. Preventive periodontal care and maintenance, including topical fluoride application when beneficial;
2. Application of unfilled resin material, known as "sealants", to the occlusal (bite) grooves of the posterior teeth as a preventive treatment against tooth decay;
3. Treatment of the soft tissues (gums) in the presence of acute or chronic periodontal disease and/or injury;
4. Treatment of diseased or injured hard tissues, including teeth with suitable dental restorations (fillings or crowns), root canal therapy, or limited oral surgery (including tooth extraction) as circumstances require;
5. Replacement of missing teeth with dental prostheses using fixed and/or removable appliances (bridgework, partial or full denture / implant restoration);
6. Non-surgical evaluation/treatment of the temporomandibular joint, myofascial pain, and/or occlusal dysfunction, including the use of bite splint therapy, and limited or full mouth adjustment / equilibration;
7. Use of conscious sedation techniques (nitrous oxide analgesia; oral medication) to control and manage anxiety or disruptive behavior

I understand and accept that there are inherent risks associated with any dental treatment and hereby acknowledge that these risks have / will be explained to me, that I will have the opportunity to ask questions regarding the recommended treatment and its associated risk, and I am satisfied with the explanation given.

I understand that there are potential risks and complications associated with the use of local anesthesia, nitrous oxide analgesia, and oral sedative medications, including allergic reaction (itching, tissue rash, breathing difficulty), pain, swelling, bleeding, bruising, hematoma (blood bruise at or near injection site), nausea, vomiting, tingling and/or numbness in area of anesthetized tissues subsequent to treatment for an indeterminate length of time, fainting, and biting of the soft tissues while numb resulting in ulceration inflammation. I also understand that in rare circumstances the risk may include severe respiratory and cardiovascular complications, including total collapse (stopping of breathing and heart function; oxygen deficiency to the brain leading to possible coma or death). I acknowledge that I have been informed of such risks.

I understand that during the course of treatment it may be necessary to alter and/or amend the prescribed treatment due to unforeseen circumstances that could not be anticipated earlier. In such cases, additional treatment will be explained. I authorize the performance of any additional treatment procedures that are deemed necessary according to the professional judgment of the dentist, after treatment has been explained.

I understand and am advised that the overall success of any recommended dental treatment requires that the patient (and parents in the case of a minor) adhere to any and all post-treatment care instructions given by the dentist and/or the dental auxiliaries. In addition, the maintenance of regular re-care visits as scheduled will directly affect the long-term success of any treatment that is given.

I understand and authorize the dentist, his dental auxiliaries, and assigns to use any radiograph, photograph, and other diagnostic materials / treatment records for the purpose of teaching, research, and scientific publication

In conclusion, I hereby state that I have read and understand this consent, that all questions with regard to dental procedures have been / will be answered to my satisfaction, and that I may require additional information whenever I deem it necessary to make an informed decision concerning my dental care. I further acknowledge and agree that this "consent to perform dentistry" will remain in effect until such time that I choose to terminate it.

Patient Name ____

Name of Guardian ___________________________________ Relationship to Patient ______________

Signature ____ Date ______________________

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for all health information maintained, created, and/or received by us before the date changes were made. You may request a copy of our privacy notice at any time by contacting our privacy officer.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members access to your health information according to their primary job functions. Every one of our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition, or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Health care operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our dental records staff, outside health or management reviewers and individuals performing similar activities.

Required by law: We may use or disclose your health information when required to do so by law, requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
Abuse or neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health responsibilities: We will use or disclose your health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders including, but not limited to voicemail messages, postcards, or letters

YOUR PRIVACY RIGHTS AS OUR PATIENT:

Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our privacy officer for a copy of the request form. You may also request access by sending us a letter. Once approved, an appointment can be made to review your records. Copies, if requested, will be $.50 for each page and the staff time charged will be $10.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary of an explanation of your health information, we will provide it for a fee. Please contact our privacy officer for a fee and/or for an explanation of our fee structure. You have the right to amend your health care information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied. You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore, they are not available). You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies). Please contact our privacy officer if you want to further restrict access to your health care information. This request must be submitted in writing. You have the right to fi le a complaint with us if you feel we have not complied with our privacy policies. Your complaint should be directed to our privacy officer. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us in writing. Request a complaint form from our privacy officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to fi le a complaint with us

Signature ____ Date ____________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____

Relationship to Patient ____

Signature ____ Date ______________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Initials _______________ Date ___________________

Reason:

AUTHORIZATION FROM FOR USE OR DISCLOSURE OF PATIENT PROTCTED HEALTH INFORMATION (PHI)

Patient Name ____

Patient's Date of Birth ____

I, ___________________________________, hereby authorize English Dental and office representatives to release the following Protected Health Information (PHI):

- ☐ Billing Information
- ☐ Clinical Information
- ☐ Insurance Information
- ☐ Appointment Information
- ☐ **ALL**

The following person(s) may receive this information:
____
____
____

____ I do not authorize English Dental and office representatives to release any of my Protected Health Information (PHI) to anyone.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice.

Signature ____ Date ____________________

FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all services rendered.

Missed Appointments
Unless we receive notice of cancellation 24 hours in advance, you will be charged $75.00. Please help us serve you better by keeping scheduled appointments.

Insurance
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to the contract. As a courtesy to you, our office provides certain services, including pre-treatment estimates which we send to the insurance company at your request. It is impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what your benefits are.** If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.
Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Payment
FULL PAYMENT is due at the time of service; unless otherwise discussed. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service.
Please indicate below the form of payment you wish to use:

- ☐ Check
- ☐ Visa, MasterCard, American Express, or Discover (A non-cash fee will apply to all credit card transactions)
- ☐ Care Credit

Unpaid balances 60 days past treatment date will be subject to a $3.50 billing fee each month until balance is paid in full. If payment is delinquent, the patient will be responsible for payment of collections, attorney's fees and court costs associated with the recovery of the monies due on the account.
I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature ____ Date ____________________

MISSED APPOINTMENT AND CANCELLATION POLICY

We ask that you make every effort to give us **at least a 24-hour advanced notice** if you cannot make your scheduled appointment. It is our policy to charge any patient a $75.00 fee for an appointment canceled less than 24 hours in advance or a patient fails to appear for an appointment.

To cancel an appointment, you must call the office at 502-499-8827. You cannot cancel or reschedule appointments via email.

Signature ____ Date ______________________