Confidential Patient Information

Date_____

Personal Information

Name_____ SS#_____

Address_____

City_____ State_____ Zip_____

Telephone: Home_____ Work_____

Cell_____ e-mail_____

Birthdate_____ Sex_____ Referred by_____

Person Responsible for Account

Name_____ Relationship _____

SS#_____ Date of birth_____

Address_____

Telephone: Home_____ Work_____

Cell_____ e-mail_____

Dental Insurance Information

Primary Insurance Co._____

Insurance Co. Address_____

Employee_____ DOB_____ Relationship_____ ___ SS#_____

Employer_____ Group #_____

Secondary Insurace: Yes_____ No_____

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature_____ Date_____

Ikeda Family Dentistry

General Consent

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include; relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring.

Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental material and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paraesthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holdings one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page:

_____ _____

Patient's signature /Parent or Guardian's signature Date

Ikeda Family Dentistry

Payment Policy

As a courtesy, we will gladly submit any dental insurance claims on your behalf. Please be aware that anything **not covered** by your insurance becomes your sole financial responsibility and is due and payable within 15 days of the processing of the claim. *Any contract or agreement you have with your insurance company is between you and them*. **It is your responsibility to know what your dental benefits are, including any exclusions or limitations of your plan.**

We promise to do our best to get any claim paid and processed as quickly as possible by your insurance. To help us accomplish this, we submit all claims electronically. In most case these claims are processed and paid within 14– 21 business days.

Any treatment that is not covered by insurance is due and payable at the time of service unless prior arrangements have been made. **Please note that any treatment estimates given are just that – estimates. It is not a guarantee that your insurance will pay the estimated amount, and any difference will be your financial responsibility.**

We base your treatment on your needs, not on insurance benefits. If a particular procedure is not covered by your plan, it is not an indication that the work is unnecessary, nor is it a dictum that not to have the recommended treatment.

We will help you maximize your benefits to the best of our ability. ***Please do your part and become familiar with your insurance benefits.***

_____ _____

Signature Date

Health Information

Ikeda Family Dentistry

Date _____

Name _____

DOB _____

Telephone: Home _____ Cell _____

Email _____

Emergency contact: Name _____ Telephone _____

Physican's Name _____

Physician's Telephone _____

Please check if you have any of the following medical conditions:

- ☐ Heart conditions
- ☐ Diabetes
- ☐ Joint Replacements
- ☐ Hypertension
- ☐ Cancer
- ☐ Asthma
- ☐ Epilepsy
- ☐ Bleed excessively
- ☐ Thyroid Condition
- ☐ Sexually Transmitted Disease
- ☐ Autoimmune Disease
- ☐ Kidney Issues
- ☐ Liver Issues
- ☐ Psychiatric Therapy
- ☐ Other _____

Please list all medications (prescription, over the counter, vitamins, herbal supplements):

Any know allergies (medicine and food):

Signature _____ Date _____

Reviewed by _____