Chapman Puderbaugh DDS
FAMILY & COSMETIC DENTISTRY

Patient Contact and Insurance Form

Name: _____
Last First MI Title

Preferred Name: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip code: _____

SSN: _____ DOB: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office? (Internet, patient, insurance, etc.): _____

Do you prefer to be contact for appointments via email, text, phone?: _____ (please circle preference)

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ Phone: _____

INSURANCE - PRIMARY

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

INSURANCE - SECONDARY

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or nor paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

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

Please explain: _____

Do you experience excessive daytime sleepiness (fall asleep anywhere, at any time)? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Have you ever had a sleep study? ☐ Yes ☐ No

Have you been prescribed a CPAP? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

Please list each one: _____

Have you ever had any surgical procedures? ☐ Yes ☐ No

Please list each one: _____

Please check those conditions that apply:

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ HIV / AIDS
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pace Maker
- ☐ Psychiatric Condition
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer

Allergies

- ☐ Codeine
- ☐ Penicillin
- ☐ Other _____

If Female, Please Answer

- ☐ Are you pregnant?
  - If so, # of Weeks _____
- ☐ Are you nursing?

Dental History

Reason for this visit? _____

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Have you ever been treated with Botox to enhance your smile? ☐ Yes ☐ No

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

Is there anything you would like to change about your smile? ☐ Yes ☐ No What _____

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Are your teeth sensitive? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No What _____

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accomodate you better during your dental visit? _____

We offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit:

Professional Tooth Whitening	Veneers	Invisalign
Sleep Appliance (snore, apnea)	Smile Makeover	Bonding
Dental Implants	Crown and Bridge	Botox
Partials/Dentures	Night/Sport Guards	

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 in my medical status.

Signature: _____ Date: _____

Chapman Puderbaugh DDS
FAMILY & COSMETIC DENTISTRY

Insurance and Financial Policy

Thank you for choosing us as your health care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment. The following is our Financial Policy which we require you to read and sign prior to any treatment.

Regarding Payment

- We require payment in full at the time of service. We excellent accept Visa, MasterCard, Discover, American Express, cash, and personal check. In addition, we offer an excellent third party no-interest payment plan.
- Checks that are returned to our office from your financial institution are subject to a $20.00 returned check fee.
- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. We ask that you please notify our office at least 24 hours in advance of your appointment time if you are unable to keep your appointment. Another patient who needs our care could be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen but we ask for your assistance in this regard to avoid a $50/hour cancellation fee.

Regarding Insurance

If you have dental insurance, you must bring proof of insurance and we will be more than happy to submit your insurance claims for you. However, please realize:

- You are responsible for all charges incurred in our office. Your insurance policy is a contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Our office is not responsible for monitoring each contract limitation or the amount of benefits used to date. If you have questions regarding your dental benefits please contact your insurance company directly.
- We cannot render services on the assumption the charges will be paid for by an insurance company. All charges are YOUR responsibility from the date services are rendered.
- We will bill your insurance as a courtesy. If we received payment from the insurance, we will issue a refund of any difference.

We must emphasize that as care providers, our relationship is with you, the patient, not your insurance company. Most importantly please inform us of any insurance changes such as policy name, insurance company address, or a change of employment.

I authorize payment of all benefits otherwise payable to me directly to Drs. Chapman & Puderbaugh, DDS.

I have read that policies described in this form. I understand and accept my financial responsibilities.

Print Name: _____ Date: _____

Patient/Parent Signature: _____

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FAMILY & COSMETIC DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____ SOCIAL SECURITY #: _____

SECTION B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy & security practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we may maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: TELEPHONE: (304)744-1251 FAX: (304)744-1279 ADDRESS: 308 C Street, South Charleston, WV 25303.

I, _____, have had full opportunity to read and consider the
Please Print Name
contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE: _____ DATE: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

PERSONAL REPRESENTATIVE'S NAME: _____

RELATIONSHIP TO PATIENT: _____

Would you like to give permission to another person to discuss your treatment needs or account information?
☐ **Yes** ☐ **No**

If yes, please list the names of anyone you wish to grant permission.

_____