Robert E. Christensen, D.D.S
Cosmetic and General Dentistry
New Patient Information

Date: _____

Last Name: _____First Name: _____

Please Circle Marital Status: ___**Single Married Divorced Separated Widowed Other**_____

Preferred Name: _____Date of Birth: _____

SSN: _____ DL #:_____

Address: _____

City_____State:_____Zip:_____

Cell: _____Work:_____Home:_____

Email: _____

How did you hear about our practice: _____

DENTAL INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Subscriber Name:_____	Subscriber Name:_____
Subscriber ID #:_____	Subscriber ID #:_____
Subscriber SSN: _____	Subscriber SSN: _____
Date of Birth:_____	Date of Birth:_____
Relationship to Subscriber:_____	Relationship to Subscriber:_____
Employer Name:_____	Employer Name:_____
Insurance Company:_____	Insurance Company:_____
Group #:_____	Group #:_____
Insurance Phone #:_____	Insurance Phone #:_____

Please present your insurance card and driver license to be scanned for our record

_____

RESPONSIBLE PARTY (If Minor)

Last Name: _____ First: _____

Address (if different):_____DOB:_____

City: _____State:_____Zip:_____

Cell: _____Work:_____Home:_____

Email: _____

EMERGENCY CONTACT

Last Name:_____First:_____

Phone #:_____

AUTHORIZATION I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance.

_____ Date: _____

Signature

Cancellation, Financial and Dental Insurance Policies

Robert E. Christensen, D.D.S. accepts several forms of payment for dental treatment provided at this office:
Cash, debit, personal check and the following credit cards (MasterCard, Visa and Discover)

Care Credit: We offer access to an outside financing company that provides a qualifying patient with an interest free loan for dental treatment. A short application is required and once the patient is approved, it is the patient's responsibility to pay all fees incurred to the financing company.

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to provide reasonable assistance to help you maximize your benefits. Most dental insurance excludes coverage for some services, uses restricted fee schedules for most services, and can decline payment based on any number of policy restrictions and limitations. All such restrictions and limitations are based on the premium paid with your policy: It coverage, exclusions, deductibles and maximums. We will recommend treatment appropriate to your dental needs, regardless of your insurance status. Our office is Out of Network with all insurance companies.

Our Courtesy service to our insured patients includes:

1. Filing your claims promptly and requesting that payment be sent directly to us.
2. Following American Dental Association guidelines for claims, coding and filing.
3. Estimating your benefits to best of our ability. Most insurance companies will not provide us with detailed information about your coverage, so any insurance figures we provide to you are only estimates.

Our expectations of you as the insured patient and/or owner of the policy:

1. You will pay to us all fee other than those estimated to be covered by your insurance company at the time of treatment.
2. You will assume responsibility for any amounts expected from your insurance company, but not received, within 30 days after treatment has been performed and the claim submitted. Please understand that the insurance policy belongs to you, and we have no leverage to obtain payment from your insurance company.
3. In the event the insurance company pay directly to you amounts that are owed to us, you agree to forward payment to us within 7 days after you receive it.

Appointment cancellations without Notice: Consider your appointment with Dr. Christensen as your personal reservation. And, as with all reservation you make, (such as airlines or hotel) there must be a cancellation policy.

1. As a courtesy to you, we will make every effort to confirm your reserved appointment. But, please do not consider it our responsibility to do so. If our attempts are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us at least 24 hours in advance to change or cancel your reserved appointment time.
2. All patients who fail to arrive for their reserved appointment or who cancel without 24 hour notice will be charged a missed appointment fee of $50. Please note that this missed appointment fee is NOT covered by insurance plans, and it is your responsibility to pay it. This fee will be waived only for unforeseen circumstances at Dr. Christensen's discretions.

We appreciate all of our patients, and it is not our intent to offend anyone. With your compliance, we will be more able to keep our schedule "on time" accommodates any emergencies, and help patients who are on our waiting list seek necessary treatment promptly. We thank you for your understanding in this matter.

I hereby authorize Dr. Robert E. Christensen, D.D.S. to release to my insurance company and information acquired in the course of my dental care. I authorize benefits to be paid directly to Robert E. Christensen, D.D.S. I understand I am Responsible for all fee incurred, regardless of status of insurance and that payment is due at time of service rendered.

Responsible Party: _____

Signature: _____ Date: _____

Witness (Staff Member):_____ Date: _____

Robert E. Christensen D.D.S.
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SECTION A: PATIENT GIVING CONSENT

Patient Name: _____
Address:_____
Telephone: _____ Email: _____
DOB:_____ SSN #: _____

SECTION B: TO THE PATIENT – READ THE FOLLOWING STATEMENTS CARE FULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practice before you decide before whether to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operation, uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of out Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practice as described in our Notice Privacy Practices. IF we change our privacy 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 maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of out Notice, at any time by contacting:

Compliance Officer: Jennifer Castaneda
Telephone: 432-684-7424
Address: 2303 West Louisiana Ave, Midland Texas 79701

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and the 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 (Parent/guardian) on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

SECTION D: FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:
____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other)please Specify _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

PRIVACY PRACTICES RECEIPT / CONSENT FORM

Robert E. Christensen D.D.S.
Cosmetic and General Dentistry

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities, and healthcare operation.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____ Date: _____
Relationship to Patient: _____

SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I, _____, understand that by signing this Consent form, I am giving my consent to Robert E. Christensen to disclose and discuss my protected health information to carry out treatment, payment activities and health care operation with the following family member:
Name: _____
Relationship: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

_____ _____
Patient's Signature (Legal Guardian, if Patient is a minor) Date

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I requested that Robert E. Christensen D.D.S. restrict the disclosure of my PHI to those specified below:

Name: _____
Name: _____

Signature: _____ Date: _____

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

DENTAL AND MEDICAL HEALTH HISTORY

PLEASE COMPLETE ALL INFORMATION- THANK YOU

DENTAL HISTORY

Reason for today's visit _____Date of last dental visit_____
Former dentist _____ Phone # _____ Date of last dental X-rays_____

Please circle if you have/had:

Bad Breath	**YES/NO**	Head, neck, jaw pain or aches	**YES/NO**	Have you ever had an allergic reaction to	
Blister on lips or mouth	**YES/NO**	Lip or cheek biting	**YES/NO**	Novocaine, local, or general anesthetics?	
Burning sensation on tongue	**YES/NO**	Loose teeth or broken fillings	**YES/NO**	YES or NO	
Chew on one side of mouth	**YES/NO**	Mouth breathing	**YES/NO**	IF Yes, please explain _____	
Cigarette, pipe , or cigar smoking	**YES/NO**	Orthodontic treatment	**YES/NO**	_____ __	
Smokeless tobacco	**YES/NO**	Nitrous Oxide	**YES/NO**	_____	
Dry mouth	**YES/NO**	Sensitivity to pressure or irritants	**YES/NO**		
Food collection between teeth	**YES/NO**	(cold, heat, sweets)		Have you ever had trouble from previous	
Clench or grind teeth	**YES/NO**	How often do you floss? _____		Dental care? YES or NO	
Growth or sore spots in your mouth	**YES/NO**	How often do you brush? _____		**If yes, please explain:** _____	
Gums swollen, tender or bleeding	**YES/NO**			_____	

Have you ever been diagnosed with Periodontal Disease? **YES/NO**

MEDICAL HISTORY

Physician's Name: _____Date of last visit:
_____
Physician's Phone #: _____ Blood Pressure: _____
Have you had any serious illnesses or operations? **YES or NO** if so, please describe _____
_____
Have you ever had a blood transfusion? _____
(Women) Are you pregnant? YES or NO Due Date: _____ Nursing? **YES or NO** Taking Birth Control? **YES or NO**

Please circle if you have/ had:

Allergies, hay fever, sinusitis	**YES/NO**	Headaches	**YES/NO**	Slow healing wounds	**YES/NO**
Anemia	**YES/NO**	Heart murmur	**YES/NO**	Stroke	**YES/NO**
Arthritis, Rheumatism	**YES/NO**	Heart problems	**YES/NO**	Swelling of feet or ankles	**YES/NO**
Artificial heart valves	**YES/NO**	Hepatitis type_____	**YES/NO**	Thyroid problems	**YES/NO**
Artificial joints (see below)	**YES/NO**	Herpes	**YES/NO**	Tonsillitis	**YES/NO**
Asthma	**YES/NO**	High Blood Pressure	**YES/NO**	Tuberculosis	**YES/NO**
Required hospitalization	**YES/NO**	Any immune deficiency	**YES/NO**	Tumor or growth on head/neck	**YES/NO**
Date of last episode_____		Jaundice	**YES/NO**	Ulcer	**YES/NO**
Have you used steroids?	**YES/NO**	Kidney disease	**YES/NO**	Venereal Disease	**YES/NO**
Blood disease, clotting disorders	**YES/NO**	Low Blood Pressure	**YES/NO**	Weight loss, unexplained	**YES/NO**
Cancer	**YES/NO**	Mitral Valve Prolapse	**YES/NO**	Do you wear contact lenses?	**YES/NO**
Chemical dependency	**YES/NO**	Osteoporosis	**YES/NO**	Do you consume alcoholic?	**YES/NO**
Chemotherapy	**YES/NO**	Osteopenia	**YES/NO**	Are you Allergic/sensitive to Latex?	**YES/NO**
Circulatory problem	**YES/NO**	Radiation treatments	**YES/NO**	Allergic to Penicillin, Aspirin, or other drugs?	
Cortisone treatments	**YES/NO**	Respiratory disease	**YES/NO**	if Yes, please specify _____	
Cough, persistent or bloody	**YES/NO**	Rheumatic fever	**YES/NO**	_____	
Diabetes	**YES/NO**	Scarlet Fever	**YES/NO**	_____	
Emphysema	**YES/NO**	Shortness of breath	**YES/NO**	**Please list any medication that you are taking**	
Epilepsy	**YES/NO**	Sinus trouble	**YES/NO**	**(over the counter and Prescribed)**	
Fainting	**YES/NO**	Sickle cell anemia	**YES/NO**	**on the next page**	
Glaucoma	**YES/NO**	Skin rash	**YES/NO**		

Do you need to Pre-Medicate for any dental cleanings/Treatment? (reason_____) **YES/NO**
If yes to Artificial joints:
Which joint(s) and date of replacement(s) _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.
Patient/Guardian Signature _____ **Date** _____

Doctor Signature _____**Date** _____

Robert E. Christensen D.D.S.
Cosmetic and General Dentistry

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DENTAL AND MEDICAL HEALTH HISTORY

PLEASE COMPLETE ALL INFORMATION- THANK YOU

Medications

Please list ALL current medication

_____
_____
_____
_____
_____
_____

If you have a current medication list, we can copy that for you and attach to this form