HOLMAN
FAMILY DENTISTRY

Centerton, AR
(479) 795-1101

**Patient Information (Confidential)** Date: _____ Social Security #_____

Name _____ Birthdate _____ Gender: □ Male □ Female

Preferred Name _____ Email _____

Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Parent/Guardian's Employer _____ Work Phone _____

Where did you hear about us? _____

Person to Contact in Case of Emergency _____ Phone # _____

**Responsible Party**

Name of Person Financially Responsible for Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

**Insurance Information**

Name of Insured (Subscriber) _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Insurance Started _____

Name of Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Dental Insurance Company _____ Group # _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

I authorize the practice to send text message or email appointment reminders.

I authorize the taking of photographs, radiographs, and diagnostic casts before, during and after treatment for use in enhancing treatment among interdisciplinary team members.

Date _____ Parent/Guardian Signature _____

Welcome

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# MEDICAL/DENTAL HISTORY

Patient's Name _____

Name of Physician _____ Date of Last Physical Exam_____ Results _____

Date of Last Visit to Dentist _____ For what service _____

List all allergies and reaction to allergen (such as drugs, metals, latex, foods, etc.) _____

_____

List all current medications, including non-prescriptions: _____

_____

List any other specials needs of the minor child: _____

| Medical and Dental | Yes | No | Date/ Details |
|---|---|---|---|
| Has child complained about dental problems | | | |
| Does child brush teeth daily | | | |
| Does child use floss daily | | | |
| Is fluoride taken in any form | | | |
| Any injuries to mouth, teeth, head | | | |
| Any unhappy dental experiences | | | |
| Is child currently under care of physician | | | |
| Has child ever been hospitalized | | | |
| Has child ever had surgery | | | |
| Excessive bleeding when cut | | | |
| AIDS/HIV | | | |
| Anemia | | | |
| Asthma/Inhaler Use | | | |
| Bladder Problems | | | |
| Cancer | | | |
| Cerebral Palsy | | | |
| **Medical and Dental** | **Yes** | **No** | **Date/ Details** |

| | | | |
|---|---|---|---|
| Chicken Pox | | | |
| Convulsions | | | |
| Diabetes | | | |
| Drug/Alcohol Abuse | | | |
| Epilepsy | | | |
| Fainting | | | |
| Hearing Problems | | | |
| Heart Problems | | | |
| Hepatitis | | | |
| Kidney Disease | | | |
| Liver Disease | | | |
| Measles | | | |
| Mononucleosis | | | |
| Mumps | | | |
| Rheumatic Fever | | | |
| Sinus Problems | | | |
| Thyroid Disease | | | |
| Tuberculosis | | | |
| Other Condition (explain) | | | |

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN CHILD'S MEDICAL HISTORY OR ANY MEDICATIONS THEY MAY BE TAKING.**

Date_____ Parent/Legal Guardian Signature _____

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**PAYMENT AND INSURANCE INFORMATION**

Methods of Payment

1. Cash, Check, Credit/Debit Card, or Care Credit

Dental Insurance

1. We are In Network Providers for Municipal Health, BCBS, MetLife, Cigna, GEHA and Connection Dental.
2. We accept Delta Dental Smiles for Kids, and MCNA for children only (up to and not exceeding 21 years old)
3. Our office will assist you in obtaining your insurance benefits specified in your contract. However, your insurance is a contract between you, your employer, and your insurance company. We will need a copy of your insurance card with the name, address and telephone number of the insurance company. Without this information, we will be unable to file your insurance and we will ask that you pay for all your charges.
4. As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the insurance payment of authorization at the end of this form. We do require that your estimated co-payment and deductible be paid at the time of service.
5. Please remember that insurance is considered a method of reimbursement.
6. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Related Information

1. Payment is due at the time services are rendered.
2. We welcome open discussion of services and fees prior to treatment in order to avoid any misunderstandings.
3. If an account is not paid within 90 days, we will refer the account to an outside collection source. You will be responsible for all fees incurred for the collection of your account, not limited to attorney fees, court costs, or collection agency fees. Furthermore, it is the patient's responsibility to keep the practice up to date on contact information including address changes.
4. Returned checks will be sent to the Prosecuting Attorney's office for collection. There is a charge of $25.00 for insufficient funds.
5. The parent/guardian that brings the child to the appointment will be held responsible for all costs associated with the dental treatment performed. The office is unable to bill or collect from a third party while you try to collect.
6. If the patient is being seen for an emergency or accident, you will be held responsible for all costs associated with the service. We will provide you with a form that you may submit to your insurance company for them to reimburse you.
7. Your appointment time has been reserved for you, any changes in your appointment time can affect other patients. As a courtesy to us and other patients, 24 hour notice of any cancellation is required to avoid a $25.00 charge.
8. We ask that you inform us of any changes in information such as address, phone numbers, or insurance information. We will ask you to update this information periodically regardless of any changes.

I have read and understand the above information. I understand I am responsible (regardless of insurance) for any charges incurred from services rendered.

NAME (PLEASE PRINT)_____

SIGNATURE: _____ DATE: _____

Insurance Assignment of Benefits: I hereby authorize payment of dental benefits to be sent to Thomas M. Holman, DDS, P.A.

SIGNATURE_____

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Patient Name:_____ Date: _____

***I may refuse to sign this acknowledgment.***

**I have been offered and/or received a copy of Holman Family Dentistry's Notice of Privacy Practices. (Copies available upon request.)**

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

**Expiration – 3 years from Initial Signature; Insurance Change; Patient reaches age of 18**

I consent for the office of Dr. Thomas Holman to share my personal information with the following: (family, friends, etc.) Please note that only individuals listed below will be allowed in the treatment/hygiene rooms for any visits.

Name/Relationship/Phone

_____/_____/_____

_____/_____/_____

_____/_____/_____

Signature: _____

□ Patient □ Parent □ Guardian/Other

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**INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES**

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by the office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment or a piece of dental instrument may be left in your body and may have to be removed at a later time if symptoms develop.
10. Jaw fracture
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and the sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication.
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

_____ _____ _____ _____

Patient/Parent/Legal Guardian Signature Date Witness/Office Personnel Date

_____

Print Patient Name