Welcome to Rodem Tree Dental !

Thank you for selecting Rodem Tree Dental, your Dental Healthcare Team. *Verified by:*________

Patient Information (All Information is Confidential) Date ____________

Name________________________________ Birthdate________________ Gender: M / F
Address________________________________ City______________ State________ Zip__________
Cell No.________________ Home No.________________
Driver's License# ______________ SSN________________ Email______________________
Employer________________________________ Work No.________________ Ok to call Y / N
Spouse or Parent/Guardian's Name ________________________ Contact Number ______________
If Student, Name of School/College ________________________ City____________ State________ FT – PT
Person to Contact in Case of Emergency________________________ Phone________________
Whom May We Thank for Referring You? ________________________________
How did you hear about us? (Circle One) INTERNENT TV POSTCARD AD PAGES SIGN BULLETIN

Responsible Party (APPLIES TO PATIENTS THAT ARE MINORS ONLY)

Person Responsible for this Account ________________________ Relationship to Patient______________
Address ________________________________ City ______________ State ________ Zip__________
Home No ______________ Cell No. ______________ Email ________________________
Driver's License# ________________ Birthdate________________ SSN________________
Employer ________________________________ Work No.________________

For your convenience, we offer the following methods of payment. Please check the option you prefer.
____Cash ____Personal Check ____Credit Card ____VISA ____Master Card ____Care Credit
Personal checks require a valid Texas Driver's License and copy of a bank card. We do not accept 3rd-party checks, unprinted checks or out of state checks.

Insurance Information

Insurance Company: ________________________________
Name of Insured ________________________________ Relationship to the Patient________________

AUTHORIZATION AND RELEASE

I authorize Dr. Ellen M. Nam, Rodem Tree Dental, to release any information including the diagnosis and the records of any treatment or examination rendered to me or any of my family members (child, spouse) for dental care to a third party payer and/or health care practitioners.
I authorize and request my insurance company to pay directly to JS Healthcare dba Rodem Tree Dental, insurance benefits for all services provided. I understand that every effort will be made to assist me with my insurance. I understand only an estimation of dental benefits can be provided by my insurance carrier.
If my insurance carrier does not pay as expected, I will be responsible for payment of all services rendered on my behalf or my dependents. If I am billed for any services, I will pay the balance within 30 days unless arrangements have been made with Rodem Tree Dental. If sent to collections, I agree to pay all related fees and court costs.

Patient/Parent/Guardian________________________________ Date________________

APPOINTMENTS AND CANCELLATIONS

When we make your appointment we are reserving a room for a set amount of time to service your particular needs. Your records are prepared, and special instruments are made ready for your visit. We feel our patient's time and our time is valuable. Therefore, there is a $50.00 charge for confirmed "No Show" appointments. We ask that if you must change an appointment, please give us a two-day (48 hour) notice in order to avoid the $50.00 fee. This courtesy will enable us to replace your appointment time with another patient.

Patient/Parent/Guardian________________________________ Date________________

Patient Medical History (All Information is Confidential)

Physician ____________________ Office Phone ____________________ Date of Last Exam ____________________

1. Are you under medical treatment now? Y / N
2. Have you had any surgeries or been hospitalized for any serious illness within the last 5 years? Y / N
   Please explain: ____________________
3. Are you taking any medications? Y / N
   If yes, what medication(s) ____________________
   ____
   ____
4. Do you use tobacco Y / N Alcohol Y / N
5. Controlled Substances Y / N
6. Unusual reaction to dental injections? Y / N
7. Joint Replacement Y / N Date ____________________

#8 IS VERY IMPORTANT, MUST BE ANSWERED:

8. Are you allergic to or have you had any reactions to the following?
   - Local Anesthetics (e.g. Novocain) Y / N
   - Penicillin or any other Antibiotics Y / N
   - Sulfa Drugs Y / N Codeine/Narcotics Y / N
   - Sedatives Y / N Iodine Y / N
   - Aspirin Y / N Latex Rubber Y / N

   Other allergies (please list) ____________________
9. Women:
   Are you pregnant or think you may be pregnant Y / N
   Are you nursing? Y / N

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

	Current	Past		Current	Past		Current	Past
Anemia	Y / N	Y / N	Emphysema	Y / N	Y / N	Kidney/Bladder Trouble	Y / N	Y / N
Arthritis	Y / N	Y / N	Epilepsy	Y / N	Y / N	Mental Health Problems	Y / N	Y / N
Asthma	Y / N	Y / N	Fainting Spells/Seizures	Y / N	Y / N	Radiation Therapy	Y / N	Y / N
Blood Clotting Problems	Y / N	Y / N	Fever Blisters	Y / N	Y / N	Respiratory Problems	Y / N	Y / N
Blood Transfusion	Y / N	Y / N	Head, neck or jaw injuries.	Y / N	Y / N	Rheumatic Fever	Y / N	Y / N
Cancer/Tumor or Growth	Y / N	Y / N	Hepatitis/ Jaundice	Y / N	Y / N	Rheumatic Heart Disease	Y / N	Y / N
Cardiac Pacemaker	Y / N	Y / N	Heart Attack	Y / N	Y / N	STD	Y / N	Y / N
Chest Pains	Y / N	Y / N	Heart Disease	Y / N	Y / N	Sinus Trouble	Y / N	Y / N
Damage Heart Valve	Y / N	Y / N	Heart Murmur	Y / N	Y / N	Stroke	Y / N	Y / N
Diabetes	Y / N	Y / N	High Blood Pressure	Y / N	Y / N	Thyroid Problems	Y / N	Y / N
Dry Mouth/Sjogren	Y / N	Y / N	HIV / AIDS	Y / N	Y / N	Tuberculosis	Y / N	Y / N

Patient Dental History

Name of previous Dentist ____________________ Date of Last Exam ____________________ Cleaning ____________________

1. Do your gums bleed while brushing or flossing ....Y / N
2. Are your teeth sensitive to hot or cold liquids/foods......... Y / N
3. Are your teeth sensitive to sweet or sour liquids/foods?..... Y / N
4. Do you feel pain to any of your teeth? .... Y / N
5. Do you have any sores or lumps in or near your mouth?... Y / N
6. Do you wear dentures or partials? .... Y / N
7. Have you ever had any prolonged bleeding following an extraction? ....Y / N
8. Do you have frequent headaches? ....Y / N
9. Do you clench or grind your teeth? ....Y / N
10. Do you bite your lips or cheeks frequently?....Y / N
11. Have you ever had any difficult extractions?..Y / N
12. Have you had any orthodontic treatment?......Y / N

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. <u>I understand that providing incorrect information can be dangerous to my health.</u>

Patient/Parent/Guardian ____________________ Date ____________________

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _______________________, have received a copy of this office's Notice of Privacy Practices.
Name of Patient (or parent if under 18 years)

____
Patient Name (Printed)

_____________________________________ _____________________
Signature of Patient (or parent if under 18 years) **Date**

****

<u>For Office Use Only</u>

Refusal to Sign

We attempted to obtain written acknowledgement of receipt of our 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 (specify):____**

_____________________________________ _____________________
Signature of Patient **Date**

_____________________________________ _____________________
Witness Signature **Date**

Rodem Tree Dental

Insurance and Financial Policy

At Rodem Tree Dental, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. We provide outstanding dental care to all of our patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Please "Initial" to acknowledging that you have read the following:

______**Your dental benefits are based upon a contract made between your employer and your insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. Insurance benefits are only meant to assist you.**

______We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally hundreds of insurance companies. Although we can maintain computerized histories of payment by a given company, they do change; **therefore it is impossible to give you a guaranteed quote at the time of service. WE ESTIMATE** your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your insurance benefits, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. If you would like to request a pre-treatment authorization please let us know. Keep in mind this is not a guarantee of coverage. A pre-treatment authorization does delay your treatment, but will give you the exact out of pocket figures you may require.

______We will bill your insurance provider for your or your dependent's treatment. If your insurance provider does not pay within 90 days, **Rodem Tree Dental** reserves the right to request payment in full from you. You will then need to collect the insurance funds that are due to you from your insurance provider. This is rare, but it is important that you recognize that the insurance you have is a legal contract between you, your employer and your insurance company. Our office is not, and cannot be a part of that legal contract. **Ultimately, you are responsible for all charges incurred in our office.**

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______**If sent to collections, I agree to pay all related fees and court costs.**

Print Name: ______________________________ **Date:** ____________________

Patient/Parent Signature: ____