DR. ROBERT W. PRICE, D.M.D.
GENERAL DENTISTRY

309.255.9750
PRICEDMD@HUSHMAIL.COM

PATIENT INTAKE FORM

FIRST NAME: _____ **M.I.** _____ **LAST NAME**: _____

PREFERRED NAME: _____ **DOB**: _____ **SEX**: Male Female

PHONE NUMBER: _____ **ALT. PHONE NUMBER**: _____

ADDRESS: _____

_____
CITY *STATE* *ZIP CODE*

EMAIL ADDRESS: _____

PREFERRED PHARMACY: Walgreens CVS HyVee Walmart Axline Moreland & Devitt Wear Drug

Other: _____

DO YOU REQUIRE ANTIBIOTICS PRIOR TO YOUR APPOINTMENT? YES NO

***This includes patients with JOINT REPLACEMENTS, HEART VALVE REPLACEMENT/REPAIRS, HISTORY OF CARDIAC INFECTIONS, AND SOME CONGENITAL HEART DISEASE.

If YES, Please contact providing physician for the prescription if needed Dr. Price will **NOT** fill the prescription prior to your visit.

DENTAL INSURANCE? YES NO (If YES, please bring the card with you to first appointment)

OTHER NOTES: Are you experiencing any tooth pain or concerns? Please explain below:

FAMILY MEMBERS (If applicable) or EMERGENCY CONTACT INFORMATION:

FIRST NAME: _____ M.I. _____ LAST NAME: _____ DOB: _____ #: _____

FIRST NAME: _____ M.I. _____ LAST NAME: _____ DOB: _____ #: _____

FIRST NAME: _____ M.I. _____ LAST NAME: _____ DOB: _____ #: _____

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PATIENT MEDICAL HISTORY

PATIENT NAME:_____ DOB: _____ DATE: _____

Please Circle One

1) Do you have a PRIMARY CARE PHYSICIAN? **YES NO** if YES: _____
2) Have you ever been hospitalized or had a major operation? **YES NO** if YES: _____
3) Have you ever had a serious head or neck injury? **YES NO** if YES: _____
4) Are you taking any medications, pills, or drugs? **YES NO** if YES: _____
5) Do you take, or have you taken, Phen-Fen or Redux? **YES NO** if YES: _____
6) Have you ever taken Fosamax (Alendronate), Boniva, Actonel, or any other bisphosphonates for osteoporosis? **YES NO** if YES: _____
7) Are you on a special diet? **YES NO** if YES: _____
8) Do you use tobacco? **YES NO** if YES: _____
9) Do you use controlled substances? **YES NO** if YES: _____

WOMEN: Are you…
☐ Pregnant / Trying to become pregnant? ☐ Nursing? ☐ Taking oral birth control?
If not oral BC, please specify which kind: _____

Are you allergic to any of the following?:
☐ Aspirin ☐ Penicillin / Amoxicillin ☐ Codeine ☐ Acrylic ☐ Other: _____
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?:

AIDS/HIV +	YES NO	Cortisone Medication	YES NO	Hemophilia	YES NO	Radiation Tx.	YES NO
Alzheimer's Disease	YES NO	Diabetes	YES NO	Hepatitis A	YES NO	Recent Weight Loss	YES NO
Anaphylaxis	YES NO	Drug Addictions	YES NO	Hepatitis B or C	YES NO	Renal Dialysis	YES NO
Anemia	YES NO	Easily Winded	YES NO	Herpes	YES NO	Rheumatic Fever	YES NO
Angina	YES NO	Emphysema	YES NO	High Blood Pressure	YES NO	Rheumatism	YES NO
Arthritis/Gout	YES NO	Epilepsy/Seizures	YES NO	High Cholesterol	YES NO	Scarlet Fever	YES NO
Artificial Heart	YES NO	Excessive Bleeding	YES NO	Hives or Rash	YES NO	Shingles	YES NO
Artificial Joint	YES NO	Excessive Thirst	YES NO	Hypoglycemia	YES NO	Sickle Cell Disease	YES NO
Asthma	YES NO	Fainting Spells/Dizziness	YES NO	Irregular Heartbeat	YES NO	Sinus Trouble	YES NO
Blood Disease	YES NO	Frequent Cough	YES NO	Kidney Problems	YES NO	Spina Bifida	YES NO
Blood Transfusion	YES NO	Frequent Diarrhea	YES NO	Leukemia	YES NO	G.I. Conditions	YES NO
Breathing Problems	YES NO	Frequent Headaches	YES NO	Liver Disease	YES NO	Stroke	YES NO
Bruise Easily	YES NO	Genital Herpes	YES NO	Low Blood Pressure	YES NO	Swelling of Limbs	YES NO
Cancer	YES NO	Glaucoma	YES NO	Lung Disease	YES NO	Thyroid Disease	YES NO
Chemotherapy	YES NO	Hay Fever	YES NO	Mitral Valve Prolapse	YES NO	Tonsillitis	YES NO
Chest Pains	YES NO	Heart Attack/Failure	YES NO	Osteoporosis	YES NO	Tuberculosis	YES NO
Cold Sores/Fever Blisters	YES NO	Heart Murmur	YES NO	Pain in Jaw Joints	YES NO	Tumors / Growths	YES NO
Congenital Heart Disease	YES NO	Heart Pacemaker	YES NO	Parathyroid Disease	YES NO	Ulcers	YES NO
Convulsions	YES NO	Heart Trouble/Disease	YES NO	Psychiatric Care	YES NO	Venereal Disease/STD	YES NO
						Yellow Jaundice	YES NO

Other medical conditions NOT listed above? **YES NO** if YES: _____

Comments:

"To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health and it is my responsibility to inform the dental office of any changes in my medical status."

Patient Signature: _____ Date: _____

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FINANCIAL AGREEMENT

***Please take a moment to read and fully understand each of the following points, check each box, and sign/date the bottom of this form. Your signature implies your ability to read, understand, and consent to the complete financial agreement.**

This office is not contracted with any dental insurance companies, we are not part of any dental insurance network, and we are not part of any PPO's or HMO's. We do not accept Medicaid or Medicare. If applicable, insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances that are not paid within 60 days may be billed to you, the patient. Please keep statements and follow-up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges is and will be your responsibility.

Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to keep your appointment may result in a charge for the time reserved, as this time could be utilized by another patient in need of care. If a 24-hour notice is not given, a cancellation fee of a minimum of $30 will apply. There will be a minimum fee of $50 for any checks returned as Non-Sufficient Funds (NSF). Patient balances that go unpaid for 60 days or more may be referred to Collection Professionals, INC. Further, in the event any unpaid account balance is referred to any attorney for collection, you may also be responsible for all costs and reasonable attorney's fees incurred in connection therewith. Please note that payment collection will be made by the provider whose office Dr. Robert Price sees you in for your appointment (either Dr. Matt McClure or Dr. Nick Doll).

- ☐ I have been informed of the treatment plan and associated fees and know that I have the right to refuse treatment.
- ☐ I allow Robert W Price, DMD to file for insurance benefits to pay for the care I receive.
- ☐ I understand that my provider, Dr. Robert W Price, will have to send my medical record information to my insurance company. To the extent permitted by law, I consent to your use and disclosure of my personal health information to carry out payment activities in conjunction with this claim.
- ☐ I must pay my share of the treatment costs not included in my insurance coverage for myself or my dependent. If uninsured, I agree to pay at the time of treatment for myself or my dependent.
- ☐ I understand that I must provide at least 24 hours' notice when cancelling an appointment and that failure to do so may result in the fee as stated above.
- ☐ I understand that I will be liable for the collection cost of a minimum of $50. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

Patient or Parent/Guardian Name (Please Print)*	Patient or Parent/Guardian Signature*	Date

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PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA")

1. Tell your provider if you do not understand this authorization and the provider will explain it to you. **Your signature implies your ability to read, understand, and consent to the complete authorization.**

2. You have the right to revoke or cancel this authorization at any time, except (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment, or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated authorization, you can receive a copy of the signed authorization.

☐ I hereby understand and agree to the above authorization.*

_____	_____	_____
Patient or Parent/Guardian Name (Please Print)*	Patient or Parent/Guardian Signature*	Date

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CONSENT TO TREATMENT

***Please take a moment to read and fully understand each of the following points, check each box, and sign/date the bottom of this form. Your signature implies your ability to read, understand, and consent to the complete agreement. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated below. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.**

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. Please do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you acknowledge 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. 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.

- ☐ I do voluntarily assume any and all possible risks which may be associated with any phase of this treatment in hopes of obtaining the desired and/or any results from the treatment to be rendered to me
- ☐ I understand that dentistry is not an exact science, therefore: reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.
- ☐ I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me
- ☐ I hereby give permission for Dr. Robert W. Price, DMD, to give me medical treatment.
- ☐ I understand I have the right to refuse any procedure or treatment.
- ☐ I understand I have the right to discuss all medical treatments with my clinician to my satisfaction.

Patient or Parent/Guardian Name (Please Print)*	Patient or Parent/Guardian Signature*	Date

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CODE OF CONDUCT

***Please take a moment to read and fully understand each of the following points and sign/date the bottom of this form. Your signature implies your ability to read, understand, and agree to the complete statement.**

Thank you for choosing Dr. Robert W. Price, DMD, to be your primary dental care physician! At our practice, our mission is to deliver exceptional care with a focus on efficiency, safety, and empathy. Your safety, comfort, and satisfaction are our top priorities. We are dedicated to providing you with the best dental treatment possible. In doing so, we ask all patients, staff, and visitors to comply with the guidelines in our Code of Conduct.

To help us maintain a positive and effective environment, we kindly ask that you observe and agree to the following:

- Provide the most accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to the patient's health.
- Report unexpected changes in condition to the responsible provider.
- Follow the treatment plan that you developed in collaboration with your provider based on your personal goals and values. This includes following the instructions of the dentist and other dental health professionals.
- Let our staff know when you don't understand the treatment plan or what is expected of you.
- Adherence to Regular Cleanings; Regular dental cleanings are vital for maintaining optimal oral health.
- Conduct yourself in a respectful and kind manner to the dentist, staff, and other patients.
- Keep appointments as scheduled or contact the practice at least 24 hours prior to that appointment to cancel or reschedule.
- Be responsible for your own actions and the consequences of those actions. If you refuse treatment or do not follow the provider's instructions, outcomes may be sub-optimal.
- Meet your financial obligation to the practice.
- Abide by any practice or public health and safety policies or regulations.
- Refrain from possession and/or use of non-prescribed drugs or alcoholic beverages.
- Be courteous with the use of your cell phone and other electronic devices.
- Supervise any underage children accompanying you.

Please be aware that consistent noncompliance with these responsibilities may affect your ability to continue receiving care at our practice. We are here to support you every step of the way and appreciate your cooperation.

Inappropriate behavior or actions that **will not be tolerated** in any capacity include, but are not limited to the following:

- Physically assaulting or threatening to inflict bodily harm.
- Sexual harassment of a team member or other patients.
- Intimidating or harassing a team member or other patients.
- Making threats of violence through any written, verbal or electronic communication.
- Damaging business equipment or property.
- Making disrespectful, menacing or derogatory gestures or remarks.
- Making racial or cultural slurs or other derogatory remarks.
- Failing to comply with financial obligations.
- Failing to comply with course of treatment.
- Having a series of missed or cancelled appointments without prior notice.

Failure to comply with these guidelines could results in excusal from our practice and possible legal action.

☐ I hereby understand and agree to the above statement.*

Patient or Parent/Guardian Name (Please Print)*	Patient or Parent/Guardian Signature*	Date