Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone (_____) _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (_____) _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone (_____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (_____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (_____) _____

Currently a Patient in our Office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

OVER

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to a "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Medications:

List medications you are currently taking and the correlating diagnosis: _____

_____

_____

Allergies:

_____

_____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient or parent if minor Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

Joseph H. Noble, DDS, PA

Consent For Treatment and Financial Responsibilities

The undersigned hereby authorizes Joseph H. Noble DDS. PA to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Noble to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Noble to any and all forms of treatment, prescribe medication, and any therapy that may be indicated. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Joseph H. Noble DDS, PA, and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to Dr. Noble. Any and all payments received by Dr. Noble from my insurance coverage will be credited to my account. I further understand that a finance charge will be added to any overdue balance.

Dental Office Responsibilities:

1.) Complete your insurance claim forms and submit them to your carrier within 24 hours of treatment.
2.) Accept direct payment from your insurance carrier and keep track of claims paid and balances still owed.
3.) If necessary, refile your insurance a second time within a 60 day period at your request.

Patient Responsibilities:

1.) To pay fees or copays not covered by your plan at the time of treatment.
2.) To provide our office with the necessary information regarding your insurance to allow claims to be filed correctly, including a **current** copy of your dental insurance card.
3.) To pay any account balance not paid by your insurance company after 2 billing attempts.
4.) If you fail to pay your account as agreed and are referred to a collection agency, you shall be responsible for any reasonable attorney fees, costs of collection, and court costs incurred in efforts to enforce this agreement.

Thank you for choosing our office. We will do all we can to help you obtain the benefits appropriate for your particular insurance plan. If you need to set up a payment plan to assist with the costs not covered by your insurance, please feel free to discuss those options with the front office. Please sign below, authorizing us to submit claims on your behalf to your carrier and that you will comply with the above.

I hereby authorize payment directly to Joseph H. Noble, DDS, PA of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental care and treatment. I grant the right to the dentist to release my dental histories and other information about my dental treatment to third party payers.

Signature Date

Acknowledgement of Receipt

Of

Notice of Privacy Practices

I, _____ have received a copy
(Name of Patient)

of Joseph H. Noble D.D.S., P.A. **Notice of Privacy practices.**

_____
(Signature of Patient)

(Staff Will Fill Out The Section Below If Patient's Signature Not Obtained)

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reasons:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining patient's signature.

_____ Language barriers kept us from obtaining patient's signature.

_____ Other _____