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Foothills Professional Building
St. Thomas, VI 00802
Tel:(340)776-6056 Fax: (340)776-8161
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Christiansted, VI 00820
Tel:(340)772-6000 Fax: (340)719-6002
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Patient Information

Today's Date: ______________________

Patient's Name: ____ Sex: [ ] M [ ] F Birth date: ______________

SS#:________________________ E-Mail Address: ____

Home phone: (_____) ____________ Cell phone: (_____) ______________ Alternate phone: (_____) _______________

Mailing Address: ______________________________________ City: _____________State:_____ Zip: __________

Patient's marital status: ____ Married ____ Widowed ____ Single _____ Minor ____ Separated ____ Divorced

Employer/School: ___________________________ Employer/School Number: (_____) _____________ Ext: _____

Spouse/Emergency Contact: ________________________________ Phone: (_____) _____________________

Whom may we thank for referring you? _______________________________________

Responsible Party *(if patient is under the age of 18)*

Name of Person Responsible: ______________________________ Birth date: __________ SS#:____________

Relation to Patient: ________ Cell Phone: (_____) ____________ E-Mail Address: ____________________

Employer: __________________________________ Work Phone: (_____) ______________ Ext: __________

Insurance Information: Do you have Dental Insurance? Yes [ ] No [ ]

Name of Insurance Company: ______________________________________ Phone: _____________________

Name of Policy Holder: ____ Relation to Patient: ______________

Birth Date: _____________ SS#: _______________ Employer: _____________________________________

Group#: ________________________________ Subscriber/ Member ID: ____________________________

Insurance Address: ______________________________City: __________________State: _____Zip:________

Dental History

Reason for today's visit: ______________________________ Date of last dental Care: __________________

Please check appropriate answers:

[ ] Bad Breath	[ ] Grinding teeth	[ ] Sensitivity to hot
[ ] Bleeding gums	[ ] Loose teeth or broken fillings	[ ] Sensitivity to sweets
[ ] Clicking or popping jaw	[ ] Periodontal treatment	[ ] Sensitivity when biting
[ ] Food collection between teeth	[ ] Sore or growths in your mouth	[ ] Sensitivity to cold

How often do you floss? _______________ How often do you brush? ________________

Medical History

Have you had any serious illnesses or operations? ______If yes (describe):_________________________

Have you ever had a blood transfusion? YES (____) No: (____) If yes, give approximate date__________________

(**Women)** Are you pregnant? ___________

Please check appropriate answers:

[ ] Anemia	[ ] Congenital Heat Lesions	[ ] Hepatitis	[ ] Scarlet Fever
[ ] Arthritis, Rheumatism	[ ] Cortisone Treatments	[ ] Hernia Repair	[ ] Stroke
[ ] Artificial Heart Valves	[ ] Cough, Persistent	[ ] High Blood Pressure	[ ] Skin Rash
[ ] Artificial Joints, Pains etc	[ ] Cough up Blood	[ ] HIV / AIDS	[ ] Shortness of Breath
[ ] Asthma	[ ] Diabetes	[ ] Jaw Pain	[ ] Swelling of Feet
[ ] Back Problems	[ ] Epilepsy	[ ] Kidney Disease	[ ] Thyroid Problem
[ ] Bleeding Abnormally	[ ] Fainting	[ ] Liver Disease	[ ] Tobacco Habit
[ ] Blood Disease	[ ] Glaucoma	[ ] Mitral Valve Prolapsed	[ ] Tonsillitis
[ ] Cancer	[ ] Headaches	[ ] Pacemaker	[ ] Tuberculosis
[ ] Chemical Dependency	[ ] Heart Murmur	[ ] Radiation Treatment	[ ] Ulcer
[ ] Chemotherapy	[ ] Heart Problems	[ ] Respiratory Disease	[ ] Rheumatic Fever
[ ] Venereal Disease	[ ] Circulatory Problems	[ ] Hemophilia	[ ] Other :___________

List Medication you are currently taking:

[ ] ADHD [ ] Seizures [ ] Autism

____

____

____

Allergies:

____

____

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with (*Name of Insurance Company)*____________________________ and assign directly to Dr. _________________all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. The above named dentist may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits. This consent will end when the current treatment plan is completed or one year from date signed below.

_______________________________ _______________________ ____________________

Signature of Patient, Parent/Guardian Relation to Patient Date

vidental
HEALTHY SMILE SOLUTIONS

VI Dental Center Insurance and Office Policy

Insurance Policies

- There is no direct relationship between this office and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits; dental insurance policies vary. While it is your responsibility to understand your insurance policy, we will do what we can to help you understand and maximize your insurance benefits. We ask that you be responsible for the payment of all treatment at the appointment when treatment is rendered. This office will generate and submit an insurance claim to your insurance company for payment/or reimbursement. Filing a claim with your insurance company does not relieve you from the responsibility of payment of all charges. Overdue/unpaid accounts will be subject to collection actions. The patient or guardian will be responsible for collection agency, attorney, court and all associated fees incurred by VI Dental Center.______ (Initial)

- While we always strive to optimize the use of dental benefits to minimize you're out of pocket cost, most plans have a yearly allotment maximum ranging from $1000-$2000. Additionally, most dental plans do not cover the costs of major reconstructions such as implants or cosmetics dentistry, braces for adults, or work deemed by the plan to be "cosmetic.______ (Initial)

- Your dental plan provides you coverage for many services, but your plan deductible amount *must* be paid at the time of service if treatment ranges from the following:
  - **Preventive** (ineligible for full mouth x-rays and/or comprehensive evaluation)
  - **Cleanings** (full mouth debridements or scaling and root planning)
  - **Basic care** (fillings, extractions, or basic restorative work)
  - **Major services** (bridges, crowns, root canals, dentures, or implants).______ (Initial)

- Waiting for insurance payment is a courtesy provided by this dental practice. We reserve the right to withdraw this courtesy at any time. We will bill your dental insurance provider(s) and accept assignment of benefits during your dental treatments. Direct assignment **will be discontinued if patient's yearly allotment has been satisfied or** recommended treatment is complete.______ (Initial)

- The insurance provider(s) are billed when treatment is rendered. It is your responsibility to supply this office with any changes to plan coverage (including cancellations), and changes with dental insurance carrier.______ (Initial)

- If you receive payment from your insurance carrier during the period which VI Dental Center has accepted assignments of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the dental office. Failure to this may result in collection action. ______ (Initial)

- If you discontinue your dental treatment for any reason other than completion of your treatment plan, you will be responsible for any unpaid balance regardless of any claims submitted to your dental insurance provider, at the time you discontinued care. ______ (Initial)

- This dental office does not promise that an insurance company will pay. If payment is denied by an insurance carrier for any reason, patient and/or insured agrees to accept financial responsibility for payment of all unpaid portions.______ (Initial)

Broken Appointment Policy

- Your appointment time has been reserved especially for you. If you are unable to keep your appointment, please notify us at least 48 hours in advance. As a courtesy to our patients, we will attempt to confirm your appointment, but it is the patient (or guardian) sole responsibility to keep scheduled appointment. Broken appointments or appointments with less than 24 hours notice will be charged $50.00._______ (Initial)

Office Payment Policy

- The best doctor/patient relationships are maintained when there is a complete understanding of the treatment and the fee. Upon your first office visit, the cost for services rendered is due in full. Your insurance will be filed for benefits due and you will be reimbursed. Upon your following office visits we ask that you pay 60% of all procedure costs at the time of service if you have active dental insurance coverage; otherwise payment is due in full._______ (Initial)

Office Fee Policy

- A fee of $75.00 will be charged for insufficient funds/returned checks._______ (Initial)

I have read and understood the above insurance policy and wish to participate in the dental office policy. I hereby agree to abide by the provisions as specified above.

____
Please Print Name of Patient

____
Please Print Name of Person Responsible

____
Patient / Guardian Signature

____
Relation to Patient

____
Today's Date

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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 of your questions are answered. By consenting to the 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.

1. Treatment to be Provided
I understand that during my course of treatment that the following care may be provided:
Examinations ___ Preventive Services ___ Restorations ___ X-Rays ___ Crowns ___ Bridges ___
Other ____
Patient Initials: ______

2. Drugs and Medications
I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials:_____

3. Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.
I Understand that during treatment it may be necessary to change or add procedures because of condition found while working on the teeth that were not discovered during examination, should this happen treatment will stop and a new treatment plan will be presented.
I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials: _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials:_____

______________________________ ________________
Patient Signature Date