Chestnut
FAMILY & COSMETIC DENTISTRY

Patient Information

Patient Name: _____ Date:_____
Last First MI

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____Driver's License # _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call:_____

Address: _____
Street Apartment #

_____ Email Address: _____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit:_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Smoking
- ☐ _____
- ☐ _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____

Please list any medicines you are taking:_____

- Name of Physician: _____ Phone:_____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Responsible Party Information (if different from prior page)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Financial Policies

Thank you for choosing Chestnut Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard or Discover Card

  We offer a 5% courtesy adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $500 or more.

- Convenient Monthly Payment Options from CareCredit
  - Allows you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Benjamin H Sumlin DDS PLLC requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. WE ARE NOT an “In-Network” provider for ANY insurance plans. This may affect the benefits available to you. If you have questions, please contact your insurance plan directly or ask one of our team members for assistance.

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

Benjamin H Sumlin DDS PLLC charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you!

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Carecredit Healthcare Credit card is Subject to credit approval

If we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Chestnut
FAMILY & COSMETIC DENTISTRY

To Our Valued Patients:

Please be advised that our practice requires a 48-hour advanced notice for cancellation or rescheduling of appointments. Otherwise, the appointments are considered “no-show” appointments.

There is a $50 charge for missed or broken appointments with less than the required notice. All cancelations left on the machine after hours will be a broken appointment. Insurance companies do NOT pay for this charge; the patient or guardian will be responsible for this fee.

This policy is an effort by our practice to provide optimal oral health for all our patients, and minimize inefficiencies associated with broken appointments. Excessive “no show” appointments may result in dismissal from this practice.

Please be courteous to our other patients that may need to schedule, and give us a 48-hour or more notice if you need to change your appointment.

We appreciate our patient’s help in this area; it only takes a phone call and we are happy to assist you with any changes.

Patient Signature_____Date_____

CHESTNUT FAMILY & COMETIC DENTISTRY

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address _____

_____

_____

I have received a copy of the Notice of Privacy of Practices for the above named practice.

Signature _____ Date_____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____

Prepared By _____

Signature _____

Date _____

CHESTNUT FAMILY & COSMETIC DENTISTRY
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Chestnut Family & Cosmetic Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail ❑ Text *In order for texting communication, I understand that it is not sent in a secure manner. I still elect to receive text.	❑ Appointment Reminders
❑ Spouse (provide name and phone number) _____	❑ Financial ❑ Treatment Plans
❑ Parent (provide name and phone number below) ❑ Other(i.e.: Nanny, Stepparent, Grandparent etc) _____	❑ Financial ❑ Treatment Plans
❑ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	❑ Financial, Treatment Plans ❑ X-Rays to referring doctor ❑ Breach notification
❑ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication,	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)