Welcome to our Bella Vista Dental Family!

We strive to make every visit to our office the best one you can have. Please fill out our new patient paperwork to the best of your knowledge so that we can use it to serve you!

First Name: _____ Middle Initial: _____ Last Name: _____
DOB: _____ Social Security #: _____ Driver's License # _____ State: ____
Gender: M☐F☐ Age: _____ Best Phone #: _____ Cell☐Home☐Work☐
Address: _____

E-Mail Address: _____
How would you like to be reminded about you appointments? Phone☐Text☐Email☐Mail☐

Please let us know how you found our office? Please Circle Below
Friend☐ Ad in Mail☐ Drove By☐ Insurance Company☐ Internet☐ Other: _____

Emergency Contact
Name: _____ Contact Phone #: _____
Relationship to you: _____

Insurance Information
Policy Holder Name: _____ DOB: _____
Insured SS #:_____ Relationship to Patient: _____
Member ID#: _____ Group ID#: _____
Insurance Company _____
Address: _____
Insurance Phone #: _____ Employer: _____

Reason for Visit Today: Circle all that Apply

New to the Area ☐	Pain/Swelling ☐	Cosmetic ☐	Cleaning ☐
2nd Opinion ☐	Consult ☐	Whitening ☐	Orthodontics ☐
Wisdom Teeth ☐	Implants ☐	Sleep Apnea ☐	Popping/Clicking Jaw ☐
Tooth Replacement ☐	Dry Mouth ☐	Smoking/Dipping ☐	Snoring ☐

Other: _____

Have you ever needed antibiotic before dental treatment? YES☐NO☐
If Yes, Explain _____

Last Dental Visit: _____

Please List ALL MEDICATIONS/VITAMINS you are currently taking: ___(We can also scan a list)_____
_____
_____
_____

Please Circle if you have any of the following:

Acid Reflux ☐	Fainting/Dizziness ☐	Pace Maker ☐	Venereal Disease ☐
Aids/HIV ☐	Glaucoma ☐	Radiation Treatment ☐	Weight Loss ☐
Arthritis ☐	Headaches ☐	Respiratory Disease ☐	Women: ☐Pregnant / Nursing ☐
Artificial Heart Valve ☐	Heart Murmur ☐	Rheumatic Fever ☐	
Artificial Joints ☐	Heart Problems ☐	Shortness of Breath ☐	☐Seizures/Epilepsy ☐
Asthma ☐	Hepatitis A B C (circle) ☐	Sinus Trouble ☐	Osteoporosis ☐
Blood Disease ☐	High Blood Pressure ☐	Special Diet ☐	Sleep Apnea ☐
Bleeding Abnormally ☐	Jaundice ☐	Stomach/Intestinal Issues ☐	
Bruise Easily ☐	Jaw Pain ☐	Tobacco Use (any form) ☐	
Cancer ☐	Kidney Disease ☐	Thyroid Disease ☐	
Chemotherapy ☐	Latex Allergy ☐	Tuberculosis ☐	
Cough (Persistent/Bloody) ☐	Liver Disease ☐	Tumors/Growths ☐	
Diabetes ☐	Mitral Valve Prolapse ☐	Ulcers ☐	

Are you under any medical treatment now? YES☐NO☐

If Yes, Please explain: _____

_____

_____

Have you ever had any adverse/allergy to any drugs/vitamins? YES☐NO☐

Please Circle any allergies that apply:

Aspirin ☐	Iodine ☐	Sulfa Drugs ☐	Dental Anesthetics ☐
Barbiturates ☐	Latex Rubber ☐	☐Penicillin/Amoxicillin ☐	Metals ☐
Codeine ☐			Other: _____

Have you had any wounds healed slowly? YES NO _____

Have you had any excessive bleeding? YES NO _____

Do you chew on one side of your mouth? YES NO If Yes, why? _____

Have you had any major operations? YES NO (If Yes, When?)_____

Do you smoke or chew tobacco? YES NO _____

Have you been treated in a hospital in the last 5 years? YES NO _____

_____

_____

Are you currently taking/have you taken any of the following?

Fosamax ☐	Didronel ☐	Actonel ☐	Zometa ☐
Ostac ☐	Boniva ☐	Skelid ☐	Blood Thinners ☐
Bonefos ☐	Aredia ☐		

_____ I acknowledge that all the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my dental provider with any changes in medical status.

_____ I understand Bella Vista Dental, as a courtesy, will file with my insurance company on my behalf, with the understanding that any portion not covered by my insurance plan I will pay at the time of service. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with my insurance company and is only an estimate.

_____ Payment is due at time of service for all procedures. We accept all major credit cards (Visa, MasterCard, Discover and American Express), Care Credit, Cash and personal checks. All returned checks are subject to a $35.00 return service fee. I agree to pay my outstanding insurance balance within 60 days. If payment is not received, a service charge will be added to the account for the current monthly billing period. Service charge will be a periodic rate of 1.5% per month. In case of default of payment, I promise to pay legal interest on the due balance, together with any collection costs and reasonable attorney fees incurred to collect the balance.

_____ I acknowledge that there is a $25.00 missed appointment fee (up to $100.00 for multiple offenses) for broken appointments with less than 48 hour notice.

_____ I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Bella Vista Dental to use and/or disclose my protected health information to carry out the following

- Treatment which includes direct/indirect treatment by the other healthcare providers involved in my treatment
- Obtaining payment from third party payers, (my dental or medical INS company)
- The day to day healthcare operations of your dental practice.

I authorize you to share all my protected health information with the following individuals:

Name	Relationship	Contact Info

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPPA. I understand I have the right to request restrictions on how my information is used and/or disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction, I understand I any revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent will not be affected.

*For more information about HIPPA and/or to file a complaint:

(202)619-0257 Toll Free: 1(877)696-6775
The US Department of Health & Human Services
200 Independence Ave, S.W.
Washington DC 20201

_____

Patient Name Signature of Responsible Party Date