Welcome to Zehren Dental

ZEHREN DENTAL
DR. PETER ZEHREN D.D.S.
DR. RYAN GERTS D.M.D.

The Zehren Dental Team Wants

To Exceed Your Expectations!

PATIENT INFORMATION (CONFIDENTIAL)

Today's Date: _____ Preferred Name:_____Email:_____

Patient's Name: _____ Date of Birth: _____/_____/_____

Social Security #: _____ - _____ - _____ □ Male □ Female □ Married □ Divorced □ Widowed

Home Phone: _____ Work Phone: _____Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Person: _____

Relationship: _____ Phone: _____

Whom may we thank for referring you to our practice? _____

Is this person currently a patient here? □ Yes □ No

How did you hear about us? □ Google □ Yellow Pages □ Church Bulletin □ WSU Transit Bus □ Other _____

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT ABOVE)

Person responsible for billing on this account: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Relationship to Patient: _____

Social Security #: _____ - _____ - _____ Phone Number: _____Work Number: _____

INSURANCE INFORMATION

Name of Insurance Subscriber: _____ Date of Birth _____/_____/_____

Social Security #: _____-_____-_____ Relationship to Patient: _____

Employer (of insurance subscriber): _____

Date of Employment: _____ Email of Insured: _____

Name of Primary Insurance Company:_____ Group #:_____

Name of Secondary Insurance Company: _____ Group #: _____

MEDICAL HISTORY

Are you under the care of a Medical Physician?

□ Yes □ No Date of Last Exam: _____

Physician's Name: _____

List any hospitalizations/surgical procedures within the past 5 years: _____

Do you require an antibiotic prior to dental work?

□ Yes □ No If yes, explain _____

List any prescription or non-prescription medications:

_____

List any medical conditions not listed: _____

Are you allergic to any of the following?

□ Local Anesthetics □ Latex □ Penicillin

□ Codeine □ Sulfa □ Other _____

Tobacco History: _____

Are you taking any of the following medications?

□ insulin □ stimulants □ blood thinner

□ tranquilizers □ pain killers/aspirin

Women: Check all that apply.

□ Are you pregnant or think you may be?

□ Are you nursing? □ Taking oral contraceptives?

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

□ High □ Low Blood Pressure
□ Heart Attack
□ Heart □ Surgery □ Stroke
□ Chest Pain
□ Heart Disease
□ Congenital Heart Defect
□ Rheumatic Fever
□ Mitral Value Prolapse
□ Heart Murmur
□ Artificial Valves
□ Epilepsy/Convulsions
□ Scarlet Fever
□ Respiratory Problems
□ Artificial Bones/Joints
□ Leukemia
□ Cancer/Tumors
□ Radiation Therapy

□ Kidney Problems
□ Liver Problems
□ Asthma
□ Angina
□ Stomach Troubles/Ulcers
□ Shingles
□ Emphysema
□ Anemia
□ Arthritis/Rheumatism
□ Diabetes
□ Sexually Transmitted Disease
□ AIDS or HIV Infections
□ Frequently Tired
□ Hepatitis/Jaundice
□ Hay Fever/Allergies
□ Tuberculosis
□ Glaucoma

□ Thyroid Problems
□ Swollen Ankles
□ Joint Replacement
□ Jaw Problems TMJ/TMD
□ Back Problems
□ Nervousness
□ Frequent Headaches
□ Frequent Neck Pain
□ Bleeding Problems
□ Cosmetic Surgery/Implant
□ X-Ray/Cobalt Treatment
□ Psychiatric Problems
□ Alcohol □ Drug Abuse
□ Difficulty Breathing
□ Sinus Problems
□ Recent Weight □ Loss □Gain
□ Chemotherapy

DENTAL HISTORY

□ gums bleed while brushing/flossing
□ sensitive to sweet or sour liquids/food
□ difficulty in opening/closing
□ bite lips or cheeks frequently

□ sensitive to hot or cold liquids/food
□ sores or lumps in or near mouth
□ received oral hygiene instructions
□ difficult extractions/bleeding

□ pain in teeth/jaw
□ grind or clench teeth
□ clicking in jaw
□ difficulty in chewing

Authorization and Release We invite you to discuss with us any questions regarding our services. The best Dental Health Services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at time of visit, unless prior arrangements have been made. If account is not paid within 60 days of the services and no financial arrangement has been made, you will be responsible for interest fees, collection, legal fees and any other expenses incurred in the collection of your account. I understand that a monthly .66% finance charge (7.92%) annually will be added to my account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I also understand that there are no guarantees in medicine and dentistry. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ □ Parent □ Guardian Date: _____

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Cancellation Policy

Your appointment time has been reserved exclusively for you, and any changes affect many other patients, Dr. Zehren's schedule, and Zehren Dental staffing. When it is necessary to change an appointment, we require a minimum of a 24 hour notice, making it possible for another patient to use that scheduled time.

We understand unforeseen circumstances arise, and we will take your situation into consideration. We realize accidents happen, family members get sick, and emergencies occur. We will do our best to accommodate these rare occasions with grace, but please remember we track these occurrences as to prevent abuse of the policy.

Thank you for your cooperation and understanding in this matter. The policy exists to maintain our service expectations and to respect all of our patients' and team's time. We appreciate your help in continuing to provide you with the best possible care.

Respectfully,

Dr. Peter J. Zehren, D.D.S. and Dr. Ryan W. Gerts, D.M.D.

Patient/Guardian Signature: _____ Date: _____

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OFFICE FINANCIAL POLICY

We would like our patients to be informed of our office financial policy. Zehren Dental is committed to providing you with the best possible care. If you have dental insurance, our goal is to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Payment for services is due in full at the time services are rendered, unless payment arrangements have been approved in advance by our staff. If you have insurance, we will gladly submit your claim, but your estimated co-pay is due on the day of service. We accept cash, personal checks, MasterCard and Visa. Returned checks and outstanding balances older than 60 days may be subject to additional collection fee and finance charges at the rate of .66% monthly (7.92% annually). Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

If you have dental insurance, you must bring a completed dental claim form or proof of insurance and we will be happy to submit your insurance claims for you. However, you must realize:

1.) Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2.) We cannot render services on the assumption the charges will be paid for by an insurance company. All charges are your responsibility from the date the services are rendered.
3.) Our fees are generally considered to fall within the acceptable range (U.C.R.) by most insurance companies and therefore are covered up to the maximum allowance determined by each carrier.
4.) Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover and will deny.
5.) Your co-pay is only an estimate. Your co-pay is due on the day of service. We can only estimate payment due based on your treatment plan given to you prior to scheduling.
6.) Upon receipt of the insurance payment, we will reconcile your account and bill or refund any difference.
7.) Please update our staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.

We try to anticipate all costs prior to treatment. Unfortunately treatment options may change during treatment and may add to your costs. We will make every effort to inform you before additional costs are incurred.

Thank you for your assistance in this important matter.

_____ _____
Patient Signature Date

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I _____(print name)__, have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information.

Signature: _____ Date: _____

Relationship to patient: _____

Minors or Dependent family members also covered by this acknowledgement (17 and under):

_____

I authorize Zehren Dental staff to discuss treatment plans, payment plans, and treatment rendered to the following:

Spouse _____ Family _____ Referring Specialist ___YES or NO___

Others not listed above: _____ _____ _____

I give permission for any correspondences from Zehren Dental (x-rays, records, referrals, etc. be sent via email or mail.)

Signature: _____ **Date:** _____

Email- _____

Cell Phone # _____ Home/Work Number _____