RENEW
FAMILY DENTISTRY

Welcome to Renew Family Dentistry

Dr. Christopher Probst, DMD

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www.renewdentistry.com smile@renewdentistry.com

PATIENT INFORMATION

Patient Name:_____ DOB:_____ Gender: Male / Female

SS #:_____ Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Work:_____ Cell: _____ Email:_____

Employer: _____

How did you hear about us?:_____

Emergency Contact Name:_____ Relationship:_____

Phone:_____

DENTAL INSURANCE INFORMATION

Name of Insured:_____ Insured's Birth Date:_____

Subscriber ID #:_____ SS #:_____ Relationship to patient: _____

Insured's Employer Name:_____

Insurance Company:_____ Group Number:_____

Phone:_____ Insurance Claims Mailing Address:_____

Please describe the main reason for your appointment.

_____

Please rate your smile. Dislike 1 2 3 4 5 6 7 8 9 10 Satisfied

When was your last Dental Examination? _____ Cleaning? _____ X-Rays?_____

Current Home Care: Tooth Brush: Manual or Electric **How often? _____ Floss:** Daily Occasionally Rarely

Circle previous dental procedures experienced: Whitening Take-home trays/Zoom In-office Cosmetic veneers/crowns Implants Ortho/Invisalign Extractions

PLEASE RATE THE IMPORTANCE OF THE FOLLOWING GOALS.

Optimal Preventative Care (proactive approach to underlying problems, preventing issues before they arise)

Not Important 1 2 3 4 5 Extremely Important Explain:_____

Optimal Restorative Care (removing old metal fillings, cavity prevention products, protecting dental work, Invisalign)

Not Important 1 2 3 4 5 Extremely Important Explain:_____

Cosmetic Options (whitening, porcelain veneers)

Not Important 1 2 3 4 5 Extremely Important Explain:_____

Please share your individual dental expectations. Explain:_____

DO YOU HAVE ANY OF THE FOLLOWING? (Circle Yes or No)

Discolored or dark teeth? Yes No
Old unsightly crown with black lines? Yes No
Spaces between your teeth? Yes No
Crowded or crooked teeth? Yes No
History of orthodontic treatment? Yes No
Any history of gum disease? Yes No
Red, swollen, bleeding or receding gums? Yes No

Chipped, thin, or worn down teeth? Yes No
Clenching or grinding your teeth? Yes No
TMJ, jaw, or muscle soreness? Yes No
Do you have a night guard/NTI? Yes No
Cover your mouth when you smile? Yes No
Anxiety with dental work? Yes No

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No
Please list below:

Physicians Name: _____ Office Number: _____

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

Condition being treated: _____

Physicians Name: _____ Office Number: _____

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

Condition being treated: _____

PREFERRED PHARMACY:

Pharmacy Name**:** _____ Phone Number**:** _____

Fax Number**:** _____ Address**:** _____

City**:** _____ State**:** _____ Zip: _____

Do you smoke or use tobacco products? Yes No
If yes please, How often? _____ How much? _____

WOMEN ONLY

Is there a chance you may be pregnant? Yes No
Are you currently nursing? Yes No

Are you taking any oral contraceptives? Yes No
Have you had a Hysterectomy? Yes No

HAVE YOU EXPERIENCED TROUBLE WITH (check all that apply):

- Thyroid
- Gag Reflex
- Joint Replacement
- Trouble Swallowing
- Herpes
- Shingles
- HIV/Aids
- Hepatitis
- Appendix
- Gall Bladder
- Bad Breath
- Ulcers/Blisters
- Headaches/Migraines
- Kidney problems
- Dry Mouth
- Diabetes
- Epilepsy/Seizures
- Stroke
- Arthritis
- Fatigue
- Dizzy Spells
- Swollen Lymph nodes
- Poor Memory
- Hair Loss
- Mood Swings
- Irritability
- Foggy Thinking
- Anxiety
- Elevated Cholesterol
- Heart Palpitations
- High Blood Pressure
- Low Blood Pressure
- Heart Murmur
- Heart Attack
- Swollen Extremities
- Chest Pain/Pressure
- Abnormal Bleeding
- Anemia
- Rheumatic Fever
- Congenital Heart Defect
- Down Syndrome
- Pacemaker/Artificial Valve
- Mitral Valve Prolapse
- Bronchitis
- Pneumonia
- Asthma
- Lung Disease
- Blood Transfusion
- Depression
- Cancer
- Chemo Treatments
- Latex Allergy
- Metal Allergy
- Ehlers-Danlos Syndrome
- Penicillin Allergy
- Sulfa Drug Allergy
- Codeine Allergy
- Alcoholism
- Drug Abuse
- Heart disease
- HPV
- Hemophilia
- Aspirin Allergy
- Food Allergies (please list below)
- Sinus Trouble

Other: _____

Please List Any Known Allergies and/or Drug Allergies:

LIST MEDICATIONS (Rx & Over-the-counter, Dosage, Frequency):

_____

_____

_____

PLEASE LIST ALL SURGERIES/INJURIES & DATE:

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been completed accurately. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN ***DATE***

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Dental Treatment & Information Acceptance Form

Please initial each section.

____ **Health Information**

I agree to disclose ALL previous illnesses, medications; medical, dental and family history. Any undisclosed information or omissions could have a negative effect on my dental and oral health. I have been informed there are oral-systemic links that can affect my overall wellness.

____ **DRUGS, LATEX and MEDICATIONS**

I understand that antibiotics and other medications can cause allergic reactions and/or anaphylaxis, which is potentially a life-threatening condition that can interfere with normal breathing. Latex allergies can cause rashes and itching. Epinephrine, which is used in some dental injections, increases heartbeat, and depending on my health status may be dangerous. Please, disclose any information on our health history forms pertaining to any known drug or latex allergies.

____ **DENTAL TREATMENT**

I authorize Renew Family Dentistry to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate to my oral health needs appropriate to my oral health needs. I also authorize Dr. Joshua Maxwell to prescribe any forms of medication, and perform any therapy that may be indicated and agreed upon. It is possible that a tooth may require endodontic treatment (root canal), even after a filling or a crown is done depending on the depth of existing restorations or decay present. This is not always predictable from radiographs alone. I also understand that if my teeth are sensitive after treatment, I must contact the office for an appointment to address my concerns.

____ **PORCELAIN CROWNS / VENEERS / BONDING & COSMETIC FILLINGS**

Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed without a remake. I have been counseled, informed and educated on how important it is to maintain a healthy balanced dental regimen achieved by complying with hygiene and dental treatment plans set out by Dr. Maxwell. I understand that many factors contribute to my oral health: stress, clenching, grinding, acidity, diet and genetics. I am aware that most people grind their teeth subconsciously, which is damaging to the teeth and can break teeth or dental restorations. I have been informed about the need to wear an occlusal guard for protection, and a bite check is suggested.

____ **PHOTOGRAPHY RELEASE**

In order to diagnose; I understand that photographs, x-rays and/or videos will be taken for my dental record.

____ **HYGIENE THERAPY**

I understand if that upon diagnosis of periodontal disease, I no longer fall under the category of a "routine" or "healthy mouth" dental cleaning. The treatment is then categorized under the periodontal dental procedure codes which require additional services than "routine" or "healthy mouth" cleanings. Bleeding gums and family history will contribute to this diagnosis.

____ **APPOINTMENT TIMES & EMERGENCY CARE**

I understand that patients are seen by appointment only. I grant permission for contacting me via telephone (work, home or cell), email or text to discuss matters related to my treatment, accounting, or dental appointments. It is our philosophy to be available to all patients and we ask for your cooperation to only use the emergency contact line for true emergencies, such as, a broken tooth or severe dental infection causing swelling and pain.

____ **COURTESY REMINDERS**

As a courtesy, I understand that Renew Family Dentistry provides a 24-48 hour reminder Text and E-Mail for all scheduled appointments. I accept that it is my responsibility to reply to any confirmation Text and/or E-Mails within 24 hours (1 business day) of my scheduled appointment. I also reserve the right to Opt Out of Text and/or E-Mail reminders and request a phone call. In the event you do not receive a courtesy reminder call, you are still responsible for keeping your appointment.

____ **TERMINATION OF THE PROVIDER - PATIENT RELATIONSHIP.**

A good relationship between a provider and the patient is essential for quality dental care. There are times when this relationship is no longer effective and the provider finds it necessary to ask the patient to find another provider. The following are examples of situations that could render this necessary:

1. Repeated missed appointments
2. Non-payment of account
3. Not following treatment recommendations
4. Misuse/Abuse of prescribed medications
5. Abusive behavior towards staff

I have received and understand the dental treatment and acceptance form of Renew Family Dentistry. I also understand that it is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN ***DATE***

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LIMITATION OF INSURANCE COVERAGE AND PAYMENT

We realize how complex and confusing dental insurance can be. We would like to highlight a common misconception, dental insurance was ***not*** designed to pay for all dental care. Most contracts have limitations and/or various degrees of co-payment. The benefits you receive are based on the contract between you or your employer and the dental insurance company, not our office. **Some services you may need or want may not be covered by your insurance benefit plan. The treatment plans are based on an estimate provided by your insurance company and are subject to their review.** There are no guarantees of coverage. Our goal is to help you achieve and maintain optimal dental care and we will not compromise your care based on restraints of an insurance company.

As a courtesy, Renew Family Dentistry will file all claims based on your PPO dental insurance plan. All Applicable deductibles, co-insurance amounts, and non-covered services amounts are due at the time service is rendered. You will be required to pay for your visit in full at the time of service if you are unable to provide the current insurance information before your scheduled appointment.

All estimated payments are collected before you are seen by the doctor and any adjustments that need to be made can be made at the end of your visit. Any final bill and/or credit will be issued once payment from your insurance company has been received. Cash, personal checks, Master Card, Visa, Discover, American Express, and Care Credit are all acceptable forms of payment in our office. Picture ID is required in conjunction with all forms of payment except cash.

We do not offer in-house financing; however, we have partnered with Care Credit which offers several short term no-interest and long term payment plans with minimal interest. You can apply for Care Credit in our office with the assistance of a staff member or online at www.carecredit.com.

I have received and understand the financial policy of Renew Family Dentistry; I also hereby give Renew Family Dentistry permission to file claims with my insurance company on my behalf.

_____

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN ***DATE***

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MISSED APPOINTMENT AND LATE CANCELLATION POLICY

A missed dental appointment presents problems for both the provider and the patient. For you, a missed dental appointment causes a delay in treatment that was recommended to help improve your dental health.

For our office, a missed dental appointment prevents us from scheduling another patient that could benefit from treatment. **We schedule individual time with each patient** to allow us to deliver the quality and personal care that every patient deserves.

Renew Family Dentistry will charge $25 to $100 for a missed appointment, late cancellation, or for failed appointment. The charge is based on the length reserved for your appointment.

We understand that things happen and schedules do change. We ask that you provide us with at least a 24 hour notice for any changes in appointment time. Failure to provide at least a 24 hour notice for changed appointments will result in a fee.

We value and appreciate you as a patient and look forward to seeing you for future appointments.

Thank you,

Renew Family Dentistry

Dr. Christopher Probst, DMD
Dr. Jiaying Ren, DMD

Patient Name (Print): _____

Print Parent/Guardian Name: _____

Patient/Guardian Signature:_____Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 9, 2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing you treatment.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. **Your Authorization:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reasons except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency situations, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law. **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.) **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment or healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

I AUTHORIZE RENEW FAMILY DENTISTRY TO DISCLOSE MY HEALTH INFORMATION TO FOLLOWING RECIPIENT(S):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name (Print): _____

Print Parent/Guardian Name: _____

Patient/Guardian Signature:_____Date: _____