PATIENT INFORMATION

Patient First Name _____ Last Name _____ MI _____
Preferred Name _____ Date of Birth _____ Social Sec Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ ext _____
Cell Phone _____ E-mail Address _____
I would like to receive electronic communication regarding appointments (circle) **TEXT** **E-MAIL** **NOT AT THIS TIME**
Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE
Subscriber Name _____
Subscriber Date of Birth _____
Relationship to Patient _____
Employer Name _____
Insurance Company _____
Insurance Phone _____
Subscriber ID _____
Insurance Group _____

SECONDARY INSURANCE
Subscriber Name _____
Subscriber Date of Birth _____
Relationship to Patient _____
Employer Name _____
Insurance Company _____
Insurance Phone _____
Subscriber ID _____
Insurance Group _____

RESPONSIBLE PARTY *(if minor)*

First Name _____ Last Name _____ MI _____
Relationship to Patient_____ Date of Birth _____ Social Sec Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ ext _____
Cell Phone _____ E-mail Address _____

DENTAL HISTORY *(new patients only)*

Reason for today's visit _____
_____
Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental x-rays _____
How often do you floss? _____
How often do you brush? _____
Please answer **YES** or **NO** to indicate if you have had any of the following:

Bad Breath	Yes	No	Blisters on lips or mouth	Yes	No	Lip or cheek biting	Yes	No
Bleeding gums	Yes	No	Burning sensation on tongue	Yes	No	Burning sensation on tongue	Yes	No
			Chew on one side of mouth	Yes	No	Mouth breathing	Yes	No
			Cigarette, pipe or cigar smoking	Yes	No	Mouth pain, brushing	Yes	No
			Clicking or popping jaw	Yes	No	Orthodontic treatment	Yes	No
			Dry mouth	Yes	No	Pain around ear	Yes	No
			Fingernail biting	Yes	No	Periodontal treatment	Yes	No
			Food collecting between teeth	Yes	No	Sensitivity to cold	Yes	No
			Foreign objects	Yes	No	Sensitivity to heat	Yes	No
			Grinding teeth	Yes	No	Sensitivity to sweets	Yes	No
			Gums swollen or tender	Yes	No	Sensitivity when biting	Yes	No
			Jaw pain or tiredness	Yes	No	Sores or growths in mouth	Yes	No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have dental insurance coverage with _____ and assign directly to **Bolt Family Dental** 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. I authorize the use of my signature on all insurance submissions.

I authorize that **Bolt Family Dental** may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Please Print Name

_____ _____
Signature Date

Medical History

Patient Name _____ Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you currently under a physician's care? Yes No If yes, please explain _____
Are you currently taking any medications? Yes No If yes, please list _____
_____
_____
_____

Are you allergic to any of the following? (circle) Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa
Other allergies _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
Do you need to pre-medicate prior to dental procedures? Yes No If yes, please explain _____
Do you use tobacco? Yes No
Do you use controlled substances? Yes No
Do you take, or have you ever taken, Phen-Fen or Redux? Yes No

Women: Are you currently pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Renal Dialysis	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatism	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Shingles	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Stomach Disease	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Cold Sores	Yes	No	Heart Murmur	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No If yes, please explain _____
_____
_____

Comments _____
_____
_____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____
Phone Number: _____ Phone Number: _____

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

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

FINANCIAL POLICY

Bolt Family Dental is more than happy to cooperate with individuals who are covered with dental insurance and as a courtesy to you, we will file your dental claims on your behalf. We ask that you carefully read your dental policy to be sure you are fully aware of any restrictions that may apply to the benefits provided. Please note, dental insurance is a contract between the insured and the insurance company, **IT IS NOT A CONTRACT BETWEEN THE DENTIST AND THE INSURANCE COMPANY.**

If a quote is given to you at any time, this is an ***ESTIMATE ONLY***. If your insurance does not pay what is quoted to you, you are responsible for the balance. We are always willing to send in pre-treatment estimate prior to any dental treatment. **PLEASE REMEMBER THAT YOU ARE RESPONSIBLE FOR YOUR CO-PAYMENT AND ALL DEDUCTIBLEES AT THE TIME SERVICE IS RENDERED**. Please let us know if we can answer any further questions concerning your dental benefits.

Lastly, by signing below you agree to be responsible for the payment of all services rendered on your behalf or on behalf of your dependents. You, (patient, parent or guardian) understand that payment is due at the time services are rendered unless other arrangements have been made prior to any dental treatment. In the event payments are not received by agree upon dates, you understand that a 1.5% finance charge (18% APR) may be added to your account. You shall also be responsible for any and all costs incurred from collecting the account should the account become delinquent.

CANCELLATION AND MISSED APPOINTMENT POLICY

Bolt Family Dental is committed to providing all of our patients with exceptional care. When a patient misses or cancels an appointment without providing proper notice, it prevents another patient from being seen. Therefore, we reserve the right to charge a fee of **$25.00** for all missed appointments which are not cancelled with a 24-hour advance notice.

This fee will be billed directly to the patient. The fee is not covered by insurance and must be paid prior to your next appointment. Multiple missed or cancelled appointments may result in a dismissal from our practice.

By signing below, you acknowledge that you have received this notice and understand this policy.

Thank you for your understanding and cooperation as we strive to best serve our patients.

Bolt Family Dental

_____

Please Print Name

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, acknowledge that I have received a copy of this offices Notice of Privacy Practices.

_____
Please Print Name

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify) _____

HIPAA RELEASE FORM

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.

This information may be released to: (circle one or more)

My spouse My children Other Do not release this information to anyone

If "other", please specify: _____

Messages

It is okay to leave a message: (circle one or more)

Home Phone Work Phone Cell Phone

If unable to reach me: (circle one or more)

You may leave a detailed message Leave a message asking me to return your call Do not leave a message

_____ _____
Signature Date

COVID-19
WAIVER OF LIABILITY AND RELEASE AGREEMENT
(Patient)

THIS IS AN IMPORTANT DOCUMENT. YOU MUST READ IT BEFORE SIGNING. IN SIGNING THIS DOCUMENT, YOU ARE WAIVING IMPORTANT LEGAL RIGHTS.

In consideration for the opportunity to receive dental treatment from _____ (the "Practice") and the professionals retained thereby, at the Practice's office located at _____ (the "Practice's Office"), and for other good and valuable consideration, I, _____ (the "Patient"), hereby state and agree as follows:

1. I recognize that my obtaining dental treatment at the Practice's Office presents risks to me, including the risk of coming in contact with the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or my contracting coronavirus disease (COVID-19), including my risk of severe illness and/or death.

2. I hereby release, acquit, waive all claims against, and forever discharge the Practice and its owners, successors, assigns, affiliates, officers, directors, administrators, representatives, principals, agents, servants, employees, independent contractors, insurers, and attorneys (collectively with the Practice, the "Indemnified Persons"), of and from any and all claims, charges, demands, promises, acts, agreements, costs, damages, debts, obligations, actions, causes of action (including but not limited to all avoidance actions of any type), suits in equity, expenses, executions, judgments, levies, liabilities, losses, and attorneys' fees, of whatever kind or nature, whether legal or equitable, liquidated or unliquidated, fixed or contingent, direct or indirect, suspected or unsuspected, accrued or unaccrued, known or unknown, present or future, asserted or unasserted, based upon, arising out of, appertaining to, or in connection with my exposure to the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or my contracting coronavirus disease (COVID-19) as a result of or in connection with my entry into the Practice's Office, receiving dental treatment at the Practice's Office, or coming in contact with any Indemnified Person at or near the Practice's Office, and all related costs, expenses, illness, or death I may suffer as a result.

3. The releases set forth and otherwise referenced herein shall be interpreted as broadly as possible and shall be completely binding and enforceable at law. I acknowledge that the releases and waivers provided for herein include all claims and/or costs, including but not limited to those they do not know or suspect to exist, and hereby waive all rights which may exist with regard to such claims and/or costs. I expressly waive the provisions of any federal, state, and local statute or regulation limiting release of unknown claims, including any statutory language stating as following: "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY, AND ANY SIMILAR LAW."

4. For Parents/Guardians: In addition to the foregoing, we/I further waive all claims against (to the same extent described in Paragraph 2), and agree to hold harmless and indemnify, the Indemnified Persons and each of them, for any illness, death, costs, expenses, or other loss sustained by the Patient which results in any way from the Patient's entry into the Practice's Office, receiving dental treatment at the Practice's Office, or coming in contact with any Indemnified Person at or near the Practice's Office.

5. I agree that I have had the opportunity to consult with an attorney prior to executing this Waiver of Liability and Release Agreement, that I voluntarily have signed the same and that I have read and understand this Waiver of Liability and Release Agreement. **I FULLY UNDERSTAND THAT, BY SIGNING THIS WAIVER OF LIABILITY AND RELEASE AGREEMENT, I AM WAIVING IMPORTANT LEGAL RIGHTS.**

IN WITNESS WHEREOF, I have signed this Waiver of Liability and Release Agreement this ____ day of _____, 2020.

Witness:	**Patient:**
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Date: _____	Date: _____

Parent's/Guardian's Signature (if Patient is under 18): The undersigned is a parent(s) or legal guardian(s) of the Patient and hereby consents to the foregoing Waiver of Liability and agrees (1) on behalf of the Patient for Patient to be bound by the provisions hereof and (2) on behalf of himself or herself and each other parent or guardian of the Patient, that all of the terms hereof, including all liability waived hereby, equally apply to and they are subject to each of them.

Signature: _____

Print Name: _____

Date: _____