Welcome

❖❖❖ LANDMARK DENTAL CENTER ❖❖❖

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. Please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help you.

Patient Information

Name _____ **Birthdate** _____ **Home Phone (_____)**_____

Address_____ **City**_____ **State**_____ **Zip** _____

Email _____ **Cell Phone (_____)**_____ **Alt. Phone (_____)**_____

Sex ☐ **M** ☐ **F** **Marital Status** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Single** ☐ **Minor** **SS#** _____

Employer/School _____ **Employer/School Phone (_____)**_____

Employer/School Address _____ **City**_____ **State** _____ **Zip** _____

Spouse or Parent/Guardian Name _____ **Work Phone (_____)** _____

Whom May We Thank for Referring You? _____

Person to Contact In Case of Emergency _____ **Phone (_____)** _____

Responsible Party (If a Minor)

Name of Person Responsible for This Account_____ **Relationship to Patient** _____

Address _____ **Phone (_____)** _____

Email _____ **Birthdate** _____ **SS#** _____

Employer _____ **Work Phone (_____)** _____

Is This Person Currently a Patient in Our Office? ☐ **Yes** ☐ **No**

For Your Convenience, We Offer The Following Methods of Payment. Please Check The Option You Prefer. Payment In Full at Each Appointment.

☐ **Cash** ☐ **Check** **Credit Card** ☐ **VISA** ☐ **MasterCard** ☐ **Discover** ☐ **American Express** ☐ **Care Credit**

Insurance Information

Name of Insured _____ **Relationship to Patient** _____

Birthdate _____ **SS#** _____ **Date Employed** _____

Employer Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Company _____ **Subscriber ID#** _____ **Group #** _____

Secondary Insurance

Name of Insured _____ **Relationship to Patient** _____

Birthdate _____ **SS#** _____ **Date Employed** _____

Employer Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Company _____ **Subscriber ID#** _____ **Group #** _____

Dental History

Reason For Today's Visit _____ **Date of Last Dental Care?** _____

Former Dentist _____ **Date of Last Dental X-Rays?** _____

Check (✔) If You Have or Have Had Problems With Any Of The Following:

☐ Bad Breath	☐Food Collection Between Teeth	☐Periodontal Treatment	☐ Sensitivity To Sweets
☐ Bleeding Gums	☐ Grinding Teeth	☐ Sensitivity To Cold	☐ Sensitivity When Biting
☐ Clicking or Popping Jaw	☐ Loose Teeth/Broken Fillings	☐ Sensitivity To Hot	☐ Sores/Growths In Mouth

Medical History

Physician's Name _____ **Date of Last Visit** _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of Phertermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, describe _____

Women only - Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Check (✔) If You Have or Have Had Any Of The Following:

☐AIDS/HIV Positive	☐Cortisone Treatments	☐Hepatitis A_____ B_____ C_____	☐Scarlet Fever
☐Anaphylaxis	☐Cough, Persistent	☐Hernia Repair	☐Shingles
☐Anemia	☐Cough Up Blood	☐High Blood Pressure	☐Shortness of Breath
☐Arthritis, Rheumatism	☐Dentures/Partials	☐Jaw Pain	☐Skin Rash
☐Artificial Heart Valves	When?_____	☐Kidney Disease/Malfunction	☐Stroke
☐Artificial Joints	☐Diabetes	☐Liver Disease	☐Swelling of Feet/Ankles
☐Asthma	☐Epilepsy	☐Material Allergies	☐Thyroid Problems
☐Back Problems	☐Fainting	(Latex, Wool, Metal, Chemicals)	☐Tobacco Habit
☐Blood Disease	☐Glaucoma	☐Mitral Valve Prolapse	☐Tonsillitis-Removed? _____
☐Cancer	☐Headaches	☐Osteoporosis Therapy	☐Tuberculosis
☐Chemical Dependency	☐Heart Murmur	☐Pacemaker/Heart Surgery	☐Ulcer/Colitis
☐Chemotherapy	☐Heart Problems	☐Radiation Therapy	☐Venereal Disease
☐Circulatory Problems	Describe_____	☐Respiratory Disease	

MEDICATIONS

List any medications you are currently taking and the correlating Diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone # ( ) _____

ALLERGIES

☐ Aspirin	☐ Local Anesthetic
☐ Tylenol	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Metal_____	☐ Other_____
☐ Latex	_____

AUTHORIZE AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a sudden change in health. I certify that I, and/or my dependents, have insurance coverage with _____ and assign Dr. Tara Scallion, directly, 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. Dr. Tara Scallion may use my healthcare 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. This consent will end when the current treatment plan is completed, or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Landmark Dental Center
Dr. Tara Scallion, D.D.S.

Financial Policy

All charges are to be paid in full on day of service. If you have insurance, we only **estimate** what your portion will be after your insurance pays. This is only an **educated guess,** because all plans are different. Your insurance coverage is a contract between you and your insurance carrier. If your insurance has not paid us in 45 days, you will be billed for the total amount. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc. You are responsible for any balance not covered by insurance, including any late fees. **By signing below, you authorize your insurance to assign benefits to Dr. Tara Scallion directly.** If financing is needed, please ask us about Care Credit.

Collections

In the event your account is turned over for collection, you will be responsible for the balance of your account, plus any and all fees charged by the collection agency.

Cancellation Policy

24 hour notice for rescheduling or cancellation of appointment is required; otherwise a $25 fee will be placed on your account. This must be paid prior to making any future appointments. Our answering machine is on for after hour messages. After 3 missed appointments in 5 years, you will be dismissed as a patient from our office. We will refer you to another dentist for treatment.

X-ray and Medical Information Release

By signing below you authorize Dr. Tara Scallion and Landmark Dental Center to furnish any medical records, x-rays, and information necessary to other caregiver offices regarding your dental or medical health.

Pain Medication

Dr. Tara Scallion **will not** give any narcotic pain medication unless you have had a **root canal or extraction.** If you are having a toothache, antibiotics will be given. After this infection has subsided, the pain will subside. Please take over the counter pain medication, such as Advil (Ibuprofen) or Tylenol (Acetaminophen) for pain relief.

Privacy Policy

We ask that only patients being seen be allowed back to the treatment rooms. This is to ensure the privacy of the other patients being seen in other rooms. Additionally, there is limited space in the treatment rooms and if you stand in the hallway, other patients will have to pass by you to go to their room, thus violating their right to privacy.

Parents of Children

Parents, please be advised, Dr. Scallion will not force your child to do anything they do not want to do. She will not hold them down, cover their mouth, or raise her voice at them. **She will, however, administer a dose of nitrous oxide for every patient under 18, at an additional cost of $40.00, not usually covered by insurance.** This allows for patient comfort and cooperativeness. It is completely safe and will make for a much better visit for a child. If your child is not cooperative or becomes upset, we will come get you. If your child is still not willing to cooperate, he/she will be referred to a pediatric dentist.

HIPAA

A full copy of the HIPAA regulations is available upon request. By signing below, you agree that you have reviewed these policies or have chosen not to review them.

Signature_____Date_____ (Copy available upon request)