Michael O'Neill DDS and Emily Spetka DDS

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Emergency Contact	Emergency Phone #
Email		Student	SSN
Health Care Guardian Name		School Name	
Health Care Guardian Phone #		Referral Type	

Person responsible/guarantor for paying bills

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

Do you have Primary Dental Insurance?

- Group No/Name
- Insurance Name
- Phone #
- Employer Name
- Subscriber Last, First
- Subscriber Address
- City, State, Zip
- Relationship to Patient — Birth Date
- Subscriber ID

Do you have Secondary Dental Insurance?

- Group No/Name
- Insurance Name
- Phone #
- Employer Name
- Subscriber Last, First
- Subscriber Address
- City, State, Zip
- Relationship to Patient — Birth Date
- Subscriber ID

Patient Medical Information

Is premedication required?

☐ Y ☐ N Premedication

Do You Take?

☐ Y ☐ N Blood Thinner Medication
☐ Y ☐ N Daily Aspirin
☐ Y ☐ N Osteoporosis Medication

MEDICAL HISTORY

☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Anemia
☐ Y ☐ N Anorexia / Bulimia
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma
☐ Y ☐ N Blood Clotting Problems
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Emphysema/COPD
☐ Y ☐ N Cholesterol
☐ Y ☐ N Cancer / Tumor
☐ Y ☐ N Leukemia
☐ Y ☐ N Damaged Heart Valve
☐ Y ☐ N Diabetes
☐ Y ☐ N Epilepsy
☐ Y ☐ N Seizures
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Fever Blisters / Herpes
☐ Y ☐ N Frequent Headaches
☐ Y ☐ N Frequent Dry Mouth
☐ Y ☐ N Gag Reflex
☐ Y ☐ N Heart Attack / Stroke
☐ Y ☐ N Heart Disease / Angina
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Pacemaker
☐ Y ☐ N Heart Bypass
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Hepatitis / Jaundice
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Joint Replacement
☐ Y ☐ N Kidney / Bladder Trouble
☐ Y ☐ N Liver Disease
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Rheumatic Heart Disease
☐ Y ☐ N Sexually Transmitted Disease
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Thyroid Problems
☐ Y ☐ N Tuberculosis

Have you ever or do you have?

☐ Y ☐ N Partials or Dentures
☐ Y ☐ N Orthodontic Treatment
☐ Y ☐ N Sensitive Teeth
☐ Y ☐ N Bleeding Gums
☐ Y ☐ N Bad taste or smell in mouth
☐ Y ☐ N Difficulty Opening Your Mouth
☐ Y ☐ N Jaw Popping or Clicking
☐ Y ☐ N Soreness of Jaw
☐ Y ☐ N Clench & Grind Your Teeth
☐ Y ☐ N Do you chew/smoke tobacco

ALLERGIC TO

☐ Y ☐ N Codeine
☐ Y ☐ N Iodine
☐ Y ☐ N Latex Rubber
☐ Y ☐ N Local Anesthetics
☐ Y ☐ N Metals
☐ Y ☐ N Epinephrine
☐ Y ☐ N Penicillin
☐ Y ☐ N Sulfa Drugs

Dental Questionnaire

Name of previous Dentist & approximate date of last cleaning? ______

Please list any specific problems with your teeth, gums, or mouth at this time? ______

Are you happy with your smile? ______

Do you want to learn how to control your dental disease and retain your teeth? ______

Medical Questionnaire

Emergency Contact

Emergency contact name and relationship to patient/ Contact Number ______

Medical Questionnaire

Please list ADDITIONAL ALLERGIES not listed above. ______

Family Physician Name & Phone Number ______

Are you currently under care of a Physician? ______

Have you ever been hospitalized? If you answered yes please list. ______

Have you had a HIP, KNEE or any JOINT REPLACEMENT? Please list with approximate date. ______

Have you had any HEART related surgery or procedures? Please list month & year. ______

Have you had any head, jaw or neck injuries? ______

Do you get frequent fever blister, mouth sores on your lips or in your mouth? ______

Women Only

Are you pregnant? If Yes, what is your due date? ______

Are you currently nursing? ______

Are you on birth control pills / fertility drugs? ______

Additional Comments or Conditions

Any Medical condition, disease or problem not listed above? Please list. ______

By signing below, I certify that all of the above information is true to the best of my knowledge.

______ ______

Patient/Guardian Signature **Date**

Patient Name________________________________ Date____________

Please list all medication you are currently taking.

It is only necessary to list dosage for Blood thinner and mental health prescriptions.

MEDICATION NAME	DOSE	REASON FOR TAKING	

Office of Dr. Michael O'Neill

&

Dr. Emily Spetka

OFFICE POLICIES FOR SERVICES RENDERED

NOTICES OF POLICY CHANGE

Effective **10/1/18** our office has revised its financial policy. Please ensure that you have read the updated policy information.

FINANCIAL POLICY

Welcome to the office of Dr. Michael O'Neill and Dr. Emily Spetka. As a courtesy, we will verify your benefits with your insurance company and gladly submit a claim for services rendered on your behalf. We will inform you of your patient **estimated** responsibility, based on the information provided to us by your insurance company. You will receive this information, prior to your scheduled appointment. A quote of benefits is not a guarantee of benefits or payment. Your claim will be processed according to your plan; if your claim processes differently from the benefits we receive, you are still liable for any balance. It is ultimately your responsibility to understand your benefits and pay any balance you may have. Payment from insurance is never guaranteed, until the claim is processed. Please understand that you are 100% financially responsible for all charges whether or not paid by insurance.

REGARDING APPOINTMENTS

We do our best to faithfully respect our patient's valuable time. Appointment delays may occur when treating emergency patients. We appreciate your patience in these situations. Please refer to the following:

FAILED APPOINTMENT FEE

The appointment time you have scheduled is reserved specifically just for you with the doctor and clinical team members, therefore, a minimum of $35 per appointment; $75 for appointments 90 minutes and longer will be charged for any failed appointment. Any appointment cancelled without 48-hour (business hour) will also be considered a failed appointment. Exceptions will apply in the case of an emergency or weather conditions. We are asking you to please give us a call to allow other patients the opportunity for an appointment, if you cannot keep your reserved appointment.

Responsible for Payment

In the case of divorce, the parent or guardian who is bringing the child in for services will be held responsible for payment, regardless of the divorce decree.

Credit Card On File

Our office gives you the option of keeping a credit card on file to ensure payment for the portion of services that your insurance does not cover, but for which you are liable.

Your credit card information is kept confidential and stored in a secure processing system. The paper authorization will be destroyed upon entry of the card into the system. The practice will charge copay amounts at the time of service. Any remaining balances that apply toward the deductible, coinsurance, copay or denials will be charged immediately after the claim is processed. Any overpayments will be credited promptly to the same card. Charges for no show or late cancellation fees will also be charged to the card on file.

What if I want to use my HSA account?

You can enter your HSA card on file to use as your credit card. You will be responsible for ensuring there are funds available to cover your fees. If your HSA does not have funds available, you will need to use an alternate card.

What if I already have payment arrangements on my account?

We will honor any payment arrangements that have already been previously set up and are being kept as promised. If you fail to keep your payment arrangements, we will revert to the new policy.

How will I know what the charges are for?

Most insurance companies will send you an Explanation of Benefits (EOB) indicating your patient's responsibility. If they are not sent to you, most insurance companies also have online access for their members to see the information. You can match your EOB to the charges on your account. You can also request a printout of your account through the front desk at our office. Do not hesitate to ask if you have any questions. We are always happy to help.

__________________________________ ________________

Signature of Patient (or Patient's Representative) Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices, which has an effective date of 4/1/2003, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

I have had full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

______________________________________ ____________________

Signature of Patient (or Patient's Representative) Date

ADDITIONAL INDIVIDUALS AUTHORIZED FOR RELEASE OF MY HEALTH OR FINANCIAL INFORMATION:

______________________________ ______________________________

______________________________ ______________________________