



Thank you for choosing Belvedere Dentistry & Orthodontics. To ensure we meet all of your dental and healthcare needs, please fill out these forms completely. If you need any assistance or have any questions, please let one of our employees know and we will be happy to assist you.

## Referrals

Referrals are very important to us! Please tell us how you heard about our office:

Google \_\_\_\_\_ Direct Mailer \_\_\_\_\_ Insurance \_\_\_\_\_ Facebook \_\_\_\_\_ Twitter \_\_\_\_\_

Other \_\_\_\_\_ If referred by word of mouth, who can we thank for referring you?

## Preferred Personal/Contact

## Information

Preferred phone number: \_\_\_\_\_ Preferred email address:

\_\_\_\_\_ Full name: \_\_\_\_\_ Preferred

name, if different from full name: \_\_\_\_\_ Sex: M F Date of Birth:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_

## Responsible Party Information (If different than patient)

Name of responsible party: \_\_\_\_\_ Preferred phone number:

\_\_\_\_\_ Address:

\_\_\_\_\_ City:

\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ **Insurance**

## Information

Name of policyholder: \_\_\_\_\_ Relationship to patient:

\_\_\_\_\_ Date of Birth of policyholder: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Insurance Company: \_\_\_\_\_ Name of Employer:

Subscriber/Member

ID:

Group Number:

Insurance

Phone Number: \_\_\_\_\_

Patient/Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

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 medication that you may be taking, could have an important interrelationship with the dental care you will receive. Keeping this in mind, please answer the following questions:

Primary care physician? Yes No If yes, doctor's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ Have you ever been hospitalized/major operation? Yes No Details: \_\_\_\_\_

Have you ever had a serious head or neck injury? Yes No Details: \_\_\_\_\_ Are you currently taking any medications, pills, or drugs? Yes No Prescriptions: \_\_\_\_\_

\_\_\_\_\_ Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, when? How long? \_\_\_\_\_ Are you on a special diet? Yes No Do you use tobacco? Yes

No

Do you use controlled substances? Yes No

Any allergies to any of the following medications?

**For our Women patients, are you:** Pregnant? Yes No Nursing? Yes No Taking birth control? Yes No Do you have any allergies to any of the following medications? (Circle where applicable)

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics Do you have, or have you had, any of the following? (Circle where applicable)

Aids/HIV Positive Cortisone Medicine Hemophilia Recent Weight Loss Alzheimer's Disease Diabetes Hepatitis A, B, or C Renal Dialysis Anaphylaxis Drug Addiction Herpes Rheumatic Fever Anemia Easily Winded High Blood Pressure Rheumatism Angina Emphysema High Cholesterol Scarlet Fever Arthritis/Gout Epilepsy or Seizures Hives or Rash Shingles Artificial Heart Valve Excessive Bleeding Hypoglycemia Sickle Cell Disease Artificial Joint Excessive Thirst Irregular Heartbeat Sinus Trouble Asthma Fainting Spells/Dizziness Kidney Problems Spina Bifida Blood Disease Frequent Cough Leukemia Stomach Disease Blood Transfusion Frequent Diarrhea Liver Disease Stroke Breathing Problems Frequent Headaches Low Blood Pressure Swelling of Limbs Bruise Easily Genital Herpes Lung Disease Thyroid Disease Cancer Glaucoma Mitral Valve Prolapse Tonsillitis Chemotherapy Hay Fever Osteoporosis Tuberculosis Chest Pains Heart Attack/Failure Pain in Jaw Joints Tumors or Growths Cold Sores/Fever Blisters Heart Murmur Parathyroid Disease Ulcers Congenital Heart Disorder Heart Pacemaker Psychiatric Care Venereal Disease Convulsions Heart Trouble/Disease Radiation Treatments Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please describe:

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Are you currently being treated for any of the following?

- Multiple Myeloma
- Breast Cancer
- Osteoporosis
- Prostate Cancer

Are you taking any of the following medications?

- Biphosphonates
- Fosamax
- Bonica
- Actonel
- Aredia
- Zometa

Please list all medications you are currently taking (We can scan list if provided) :

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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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

\_\_\_\_\_ Date:

\_\_\_\_\_ Signature of Patient or Responsible Party



## Acknowledgement of Privacy Practices

By signing below, I acknowledge that I understand the office's Privacy Policy.

Patient or Responsible Party Signature: \_\_\_\_\_ Date:

# HIPAA Authorization

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used for the following:

Provide and coordinate my treatment among health care providers who may be involved in the treatment directly or indirectly.

Obtain payment from third party payers for my health services.

Conduct normal health care operations such as quality assessment and improvement activities

I understand that I may request in writing how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that the office is not required to agree to my requested restrictions, but if they do agree they are bound to abide by such restrictions.

In addition to the allowable described above and in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my health care information to the person(s) listed below.

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Patient or Responsible Party Signature:

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## Appointment Policy:

Thank you again for choosing Belvedere Family Dentistry for your dental care. We strive to provide you with the highest quality care. In order to ensure we provide you with the best possible care, we kindly ask the following:

Please be on time for your appointment.

No cell phone usage in our office.

If you are a parent or guardian of a child under 18 years old, you **MUST** be inside the office while we treat your child.

## Dismissal Policy:

We reserve the right to dismiss you as a patient for any broken appointment following your first broken appointment. A broken appointment means not calling 24 hours in advance of your appointment or are greater than 10 minutes late to your appointment. We value your time, and we kindly ask for the same in return.

## Confirmation Policy:

Please note a confirmation is needed to secure your reserved time slot. This ensures we are able to best serve all patients scheduled for the day. Failure to confirm by 12pm two days prior to your scheduled appointment may result in loss of your reserved time slot or increased wait times. Cancellations made less than 48 hours prior to your appointment and no-shows may result in a fee.

## Rainy Day Courtesy:

As part of our commitment to provide top notch dental care to all of our patients, if ever you have an appointment scheduled during inclement weather, please call or text us upon arrival to be met at your car with an umbrella and escorted inside.

Thank you in advance for your continued patronage.

# Dr. Jason Bansch

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Patient or Responsible Party Signature:

\_\_\_\_\_



## Financial and Insurance Policies

We are committed to providing you with the highest quality of dental care using only the best materials and education available. In doing so, we have formulated the following policies to help keep the cost of dentistry down, and to continue to provide quality care to our valued patients.

Partial deposit is required at time of scheduling, typically 60%, with the remaining 40% of the accepted and scheduled treatment plan due at the beginning of the next appointment. Our office accepts cash, official checks, Mastercard, and Visa, as well as flexible monthly payment options such as CareCredit and Sunbit. We will still estimate and bill out to insurance, but the remaining patient portion will be factored into the initial deposit.

If you have dental insurance, we will help you process your insurance claims. Please remember, however, that you are responsible for the portion of your treatment not covered by insurance. We must also emphasize that as your dental care provider, our relationship is with you-- our patient, not with your insurance company. Your insurance plan is a contract between you, your employer, and the insurance company.

Returned checks and balances older than 60 days will be subject to administrative fees and finance charges. Accounts submitted to court will be charged a \$50 administrative fee. Additionally, charges of \$50 will be incurred for broken appointments and appointments cancelled without 24-hour advanced notice. Failure to give 24-hour advanced notice for the cancellation of an appointment may result in the office not being able to reappoint you.

If you have any questions or concerns regarding our policies, please feel free to ask the receptionist or office manager. I

understand my responsibilities as outlined above and agree to abide by them.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Patient or Responsible Party's Signature:  
\_\_\_\_\_



## Broken Appointment Policy

At Belvedere Dentistry, we are committed to providing the highest quality care to all our patients. To ensure that we can serve everyone efficiently and effectively, we have implemented the following appointment policy:

### **Cancellation Notice:**

We kindly ask that you cancel or reschedule your appointment(s) at least 48 hours in advance. This advance notice allows us to accommodate other patients who may be waiting for an appointment and helps us maintain an optimal schedule for everyone.

### **Cancellation Fee:**

If you fail to cancel your appointment within the 48-hour window, a \$50 cancellation fee will be charged to your account. This fee helps cover the costs associated with the time reserved specifically for you, which cannot be filled on short notice. Please note, appointments **cannot be cancelled via voicemail or text message**. You must speak to a member of our team to properly document and cancel/reschedule your appointment.

### **Multiple Broken Appointments:**

We understand that emergencies happen. However, more than one broken appointment without proper notice may result in dismissal from our practice. Consistently missing appointments impacts our ability to provide timely care to other patients.

### **Value of Time:**

We value your time as much as our own. Our team strives to run on schedule, respecting the time you have set aside for your dental care. Similarly, we ask that you respect the time we allocate for your appointment by adhering to this policy.

### **Importance of Communication:**

Open communication is key to a successful patient-provider relationship. If you have any concerns or foresee any issues with your appointment, please let us know as soon as possible. We are here to assist you and ensure your experience with us is positive.

Thank you for your understanding and cooperation. By adhering to this policy, you help us maintain a high standard of care and ensure that we can meet the needs of all our patients.

I have read and understand the Broken Appointment Policy. I agree to abide by the terms outlined above.

Patient's Name:

\_\_\_\_\_ Date:

\_\_\_\_\_ Patient or Responsible Party's Signature:

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