Welcome!

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach exceptional oral care that will enable you to have a beautiful smile that lasts a lifetime.

1 Patient Information

Today's Date _____

First Name _____ MI _____

Last Name _____

Birthdate _____ Age _____ SS# _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Address _____

_____

Home # _____ Cell # _____

Employer _____ Work # _____

Occupation _____

Email _____

Referred by _____

Emergency Contact Name: _____

Emergency Contract Phone # _____

2 Responsible Party

First Name _____ MI _____

Last Name _____

Birthdate _____ Age _____ SS# _____

Employer _____ Work # _____

Occupation _____

Employer's Address _____

_____

3 Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS# _____

Policy Owner's Employer _____

Employee's Address _____

_____

Orthodontic Coverage? ☐ Yes ☐ No

4 Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS# _____

Policy Owner's Employee _____

Employee's Address _____

_____

Orthodontic Coverage? ☐ Yes ☐ No

5 Dental History

Purpose of today's visit _____

Previous Dentist _____

Date of last visit _____

What was done _____

Last Cleaning _____

How often do you brush _____ Gums bleed ☐ Yes ☐ No

Any ☐ Sensitive teeth ☐ Loose teeth ☐ Broken fillings

☐ Jaw pain ☐ Injuries to teeth

Explain _____

Unpleasant Dental Experience ☐ Yes ☐ No

Explain _____

Have you ever had ☐ Orthodontics ☐ Gum Treatment ☐ Implants

☐ Root Canal ☐ Oral Surgery ☐ Crowns ☐ Veneers

Are you happy with the appearance of your teeth?

☐ Yes ☐ No ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ☐ Yes ☐ No

☐ In Office ☐ Overnight ☐ Drug Store

Are you interested in replacing any missing teeth? ☐ Yes ☐ No

Which method ☐ With Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ☐ Yes ☐ No

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed to provide recommended treatment.

(NAME OF PATIENT)

6 Medical History

Physicians Name _____

Office Address _____

_____

Telephone _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Explain _____

Has there been a recent change in your health? ☐ Yes ☐ No

Explain _____

Are you currently taking any prescription, over the counter or recreational drugs? ☐ Yes ☐ No

Explain _____

_____

_____

_____

Have you been hospitalized or had a serious illness within the past five years? ☐ Yes ☐ No

Explain _____

Have you been treated now or in past with Bisphosphonates for Osteoporosis or cancer? ☐ Yes ☐ No

Explain _____

Are you Pregnant or is it likely that you could be pregnant at this time? ☐ Yes ☐ No

Explain _____

Do you?

☐ Smoke Packs per day?_____ How long?_____
☐ Chew Tobacco
☐ Drink Per week? _____Per Month?_____
☐ Wear Contact Lenses
☐ Take Diet Pills
☐ Take Herbal Supplements

Circle if you have or ever had

Y	N	Artificial Limb/joint/hip	Y	N	Chronic Diarrhea
Y	N	High/low Blood Pressure	Y	N	Stoke TIA
Y	N	Organ Transplant	Y	N	Joint Surgery
Y	N	Sinus Problems	Y	N	Cancer/Chemotherapy
Y	N	Migraines	Y	N	Blood Disorder
Y	N	Frequent Headaches	Y	N	Increased Frequent
Y	N	Claustrophobia			Urination
Y	N	Artificial Heart Valve	Y	N	Bells Palsy
Y	N	Prolonged Bleeding	Y	N	Heart Disease
Y	N	Ulcers/colitis	Y	N	Diabetes
Y	N	Hay Fever	Y	N	Asthma
Y	N	Head injury	Y	N	Night Sweat
Y	N	Venereal Disease	Y	N	Psychiatric/Emotional
Y	N	Mitral Valve Prolapse	Y	N	Recurrent Infections
Y	N	Acid Reflux	Y	N	Angina
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Epilepsy/seizures	Y	N	Bronchitis
Y	N	STD	Y	N	Addictions
Y	N	Rheumatic Fever	Y	N	Pace Maker
Y	N	Radiation Therapy	Y	N	Liver Problems
Y	N	Stomach Problems	Y	N	Emphysema
Y	N	Glaucoma	Y	N	TMJ Problems
Y	N	Dizziness/Fainting spells	Y	N	Shortness of Breath
Y	N	Treated for AIDS,HIV, ARC	Y	N	Hepatitis: A or B or C
Y	N	Heart Murmur	Y	N	Tuberculosis
Y	N	Thyroid Problems	Y	N	Unexplained Weight Loss
Y	N	Used Diet Drug Fen-Phen	Y	N	Mouth Ulcers
Y	N	Anemia	Y	N	Aspirin Daily

Please mark any allergies/adverse reactions :

Y	N	Penicillin	Y	N	Aspirin
Y	N	Tetracycline	Y	N	Valium
Y	N	Erythromycin	Y	N	Barbiturates
Y	N	Sulfa	Y	N	Latex
Y	N	Local Anesthetics	Y	N	Iodine
Y	N	Codeine	Y	N	Household
Y	N	NSAID (Advil/Motrin)			Bleach
Y	N	Gluten	Other _____		

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Dentist Signature Date

PATIENT CONSENT FOR TREATMENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account. I further understand that a late charge will be added to any overdue balance.

PATIENT Signature (Parent of Child) _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ have seen a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

FOR OFFICE USE ONLY

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

___ Patient / Parent or Legal Guardian refused to sign form

___ Other

_____ _____

Signature of Office Staff Date

Financial Policy

Thank you for choosing our practice to serve your dental needs.
Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may <u>not</u> be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month
18% APR collections fees (up to 25% of the full balance)
Legal fees for collection services

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Name Witnessed By