Welcome to our Practice

Date_____

Patient Information

Patient Name_____ What do you prefer to be called?_____

Date of Birth _____ Age_____SSN_____ Circle: Male / Female

Address_____City_____State/Zip_____

Mailing Address if different from above_____

Home Phone #_____ Work Phone #_____ Cell #_____

Employer_____ How Long?_____Occupation_____Spouse's Name_____

Employer Address _____ Referred By_____

Person Responsible for Account

Name_____ SSN _____ Date of Birth_____

Billing Address_____

Home Phone #_____ Work Phone #_____ Cell#_____

Primary Dental Insurance

Member Name_____ SSN_____ ID #(if different)_____

Member Date of Birth_____ Phone #_____ Relation to Patient _____

Employer Name_____ Phone #_____ Group #_____

Insurance Company_____ Phone #_____

Address_____

Secondary Dental Insurance

Member Name_____ SSN _____ ID #(if different)_____

Member Date of Birth _____ Phone #_____ Relation to Patient _____

Employer Name_____ Phone #_____ Group #_____

Insurance Company_____ Phone #_____

Address_____

Emergency Information

Who should we contact?_____ Relation to Patient_____

Home Phone #_____ Work Phone #_____ Cell #_____

Who is your Medical Doctor?_____ City_____ Phone #_____

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

How is your general health? ☐ Good ☐ Fair ☐ Poor

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

Approximate date of last physical examination: _____ Physician:_____

Please list any medication, drugs, or pills you are now taking and indicate dose. Include vitamins and aspirin:

_____

Are you allergic to any of the following;

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other_____

Please check any of the following conditions you may have had or have presently:

General Conditions

- ☐ Stroke
- ☐ Kidney Problems
- ☐ Ulcers
- ☐ Lung Problems (shortness of breath)
- ☐ Emphysema, Asthma, Hay Fever
- ☐ Allergies or Hives
- ☐ Sinus Trouble
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer/Tumor and related treatment
- ☐ Glaucoma
- ☐ Artificial Joints
- ☐ Arthritis/Rheumatism

Illnesses

- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Psychiatric Treatment
- ☐ Scarlet Fever
- ☐ Tuberculosis (TB)
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Liver Problems (Yellow Jaundice)
- ☐ Venereal Disease
- ☐ Syphilis, Gonorrhea, etc.
- ☐ AIDS/HIV Positive
- ☐ Chemical Dependency
- ☐ Tobacco, Alcohol, drugs

Heart Problems

- ☐ Heart Failure, Disease or Attack
- ☐ High Blood Pressure
- ☐ Artificial Heart Valve
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Congenital Heart Lesions
- ☐ Angina
- ☐ Congenital Heart Disorder

Blood Problems

- ☐ Anemia
- ☐ Hemophilia
- ☐ Bruise Easily
- ☐ Excessive Bleeding

Do you have any disease, condition or problem not listed?_____

For Women only: Are you pregnant? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

For new patients only:

Check if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Sensitivity to biting
- ☐ Grinding/Clenching teeth
- ☐ Periodontal Treatment
- ☐ Clicking or Popping Jaw
- ☐ Sensitivity to hot or cold
- ☐ Bleeding Gums
- ☐ Loose teeth or broken fillings
- ☐ Sores or growths in mouth

Have you experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment_____

Please update form and medical history yearly.

Date/Initial _____ _____ _____ _____

MEDICAL REVIEW (For office use only):_____

	Review Date				
	Examiner				

PAYMENT POLICY: Payment is due at the time of service. If the office bills your insurance on your behalf, any deductibles, co-payments, and fees for other ineligible or uncovered services, are payable at the time of visit. We will call your insurance company or estimate from past payments what your portion will be. **For current patients: If you have had statements sent and have paid your account in full after each service, we will continue to send you statements.**

We will not carry accounts longer than 90 days. We accept Cash, Check, Visa and Mastercard. With your authorization, we can debit credit cards each month on a specific day. For patients that do not have insurance, we also offer a Senior Discount (60+) of 5%. **Any unpaid balances will accrue interest at the rate of 1.0% per month with a minimum charge of $1.00 after 30 days**.

A note on insurance billing and payment of claims:

We are happy to help you file the necessary forms so that you receive the full benefits of your dental insurance; however, **we make no guarantee of any estimated coverage**. The percentage of coverage by your insurance company may be based on the company's own reduced fee schedule for dental services and may be less that the actual charges. We have no control over this situation. Lower payment is a direct result of the plan selected by your employer. The office will make every reasonable effort to help you obtain the benefits you deserve and to resolve any disputed claims. Please be advised that we are required by law to collect co-payment and therefore cannot waive it. Because the insurance policy is an agreement between you and the insurance company, **all patients are responsible directly for all charges.** The deductible for the year and any co-payments are due as treatment progresses. Any charges that become 90 days or more past due are due upon receipt of you statement, even if processing of the insurance claim is still pending.

CANCELLATION/MISSED APPOINTMENT POLICY: Although emergencies come up and appointments sometimes need to be rescheduled, a fee for insufficient notice and missed appointments will be assessed. We reserve a time slot especially for you when an appointment is made. The cost of needlessly missed appointments and late notices is borne by us all – in overhead, in time and energy, in other patients that could have been seen, and eventually, in patient fees.

- Please let us know at least 24 hours (one business day) before canceling an appointment.
- **Your account may be charged a $75 per hour fee or a minimum of $40 for failed appointments or for appointments that are canceled with less than 24 hours notice.**
- If you notify us with less than 24 hours notice, we will make every effort to fill your slot. If we can not, you may be charged the fee.

CONSENT: The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with myself or my dependent. I further authorize and consent that the doctor choose and employ such assistance as he deems fit. I understand the use of anesthetic agents and certain treatments embody some risk. In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed in an informed fashion.

I understand that responsibility for payment for dental services provided in the office for myself or my dependent is mine and arrangements for payment will be made before initial treatment begins. Breach of this responsibility carries the penalty of late fees, interest, or compensation of the doctor's attorney and collection fees (minimum $50). Broken or missed appointments may carry a minimum $40 fee (or $75 per hour) to be charged to your account. For insurance purposes, I authorize release of any information relating to claims, and I authorize payment of the group insurance benefits to my dentist, otherwise payable to me.

I have read the above and fully understand it. I also have read the Payment and Cancellation Policy. 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 or billing information. I have asked questions about anything unclear to me and I am satisfied with the answers I have received.

Signature_____ **Date**_____