**Today's Date:** _____

# PATIENT INFORMATION

PATIENT 'S NAME Last_____ First _____ Middle Initial ____ SEX: M F

ADDRESS: _____ City _____ State ____ Zip Code _____

SOCIAL SECURITY #_____ BIRTH DATE _____ AGE _____ Marital Status____

CELL PHONE _____ WORK PHONE _____HOME PHONE_____

**E-Mail Address** _____ If Patient is a minor, Parent's or Guardian's Name_____

# SUBSCRIBER INFORMATION

NAME Last _____ First _____ Middle _____ Marital Status _____

ADDRESS: _____ City _____ State ____ Zip Code _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

SOCIAL SECURITY # _____ BIRTH DATE _____ Relation to Patient _____

EMPLOYER _____ Driver's License # _____

## DENTAL INSURANCE INFORMATION

INSURED'S NAME _____

INSURANCE CO. _____

INSURED'S SS# _____ GROUP# _____

## EMERGENCY CONTACT INFORMATION

NAME: _____

PHONE _____

## DENTAL HISTORY (CIRCLE YES OR NO AS NEEDED)

Are you having PROBLEMS or DISCOMFORT now ? YES NO

If YES, PLEASE DESCRIBE:

Date of last FUNCTIONAL BITE ASSESSMENT ?

Do you wear DENTURES ? YES NO

Have you noticed any loosening of your teeth? YES NO

Are you APPREHENSIVE about dental treatment ? YES NO

Have you had any PERIODONTAL (GUM) treatment ? YES NO

Do your gums BLEED, or feel TENDER or IRRITATED ? YES NO

Are your teeth SENSITIVE to hot, cold, sweets, pressure?(circle) YES NO

Are you aware of GRINDING or CLENCHING your teeth ? YES NO

Do you have HEADACHES, EARACHES or NECK PAINS ? YES NO

Have you worn BRACES on your teeth ? (ORTHODONTICS) YES NO

Do you have DISCOLORED teeth that bother you ? YES NO

Does food tend to become caught between your teeth? YES NO

Are you UNHAPPY with the appearance of your TEETH or SMILE? YES NO

If YES, PLEASE DESCRIBE:

HOW WOULD YOU LIKE YOUR TEETH TO LOOK ?

Do you have SPACES between your teeth that you don't like ? YES NO

Circle any of below which are your concerns when having dental treatments:

SLEEPING OR SNORING PROBLEMS CONCERN WITH APPEARANCE

CONCERN WITH SMILE CONCERN WITH CHEWING COMFORT

Are you PREGNANT ? N/A YES NO

Do you SMOKE ? YES NO

## MEDICAL HISTORY (CIRCLE YES OR NO AS NEEDED)

**Are you under a PHYSICIAN'S CARE now ?** **YES NO**

**If YES, Please Describe**

**What MEDICATION are you currently taking ?**

**Circle any of the following which you have had, or presently have:**

| | | |
|---|---|---|
| Heart Disease or Attack | A.I.D.S./A.R.C./HIV POS. | Bruise Easily |
| High Blood Pressure | Hepatitis A (Infectious) | Emphysema |
| Low Blood Pressure | Hepatitis B (Serum) | Tuberculosis (TB) |
| Heart Murmur | Liver Disease | Asthma |
| Rheumatic Fever | Blood Transfusion | Hay Fever |
| Congenital Heart Lesions | Drug/Alcohol Addiction | Sinus Trouble |
| Mitral Valve Prolapse | Hemophilia | Allergies or Hives |
| Artificial Heart Valve | Fever Blisters | Diabetes |
| Heart Pacemaker | Epilepsy or Seizures | Thyroid Disease |
| Any Type of Surgery | Nervousness | Radiation Treatment |
| Prosthetics (Hip, Knee, Ear) | Glaucoma | Arthritis |
| Anemia | Psychiatric Treatment | Cortisone Medicine |
| Stroke | Cancer/Chemotherapy | Pain in Jaw Joints |
| Kidney Trouble | Slow Healing Sores | Swelling in Joints |
| Unusual Weight Fluctuation | Ulcers | Angina |

**ARE YOU ALLERGIC TO or HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS ?**

| | | |
|---|---|---|
| ASPIRIN | LOCAL ANESTHETIC | ERYTHROMYCIN |
| NITROUS OXIDE | CODEINE | PENICILLIN |

Are you aware of being allergic to any other medications or substance ? YES NO

If YES, PLEASE LIST:

Any other Medical, Dental or Family History information that you feel I should know about ?

FAMILY PHYSICIAN:

CITY, STATE: PHONE:

## CONSENT

The undersigned hereby authorize the doctors to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all 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 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 payment 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 (If minor, Parent or Guardian) _____ Date _____

## Dear Patient:

Our Office is mostly happy to complete and submit most insurance claim forms. Please keep in mind that most insurance companies **do not cover all dental expanses**. We encourage you to discuss any questions you may have regarding your specific plan with our office management and insurance department staff. Questions about your dental care should be directly discussed with your doctor. Thank you for the opportunity to serve you.

Please read and sign below showing you have understand the following:

- I understand that my insurance policy may/may not cover all dental services and that it is my responsibility to call my insurance company to verify my/my family's coverage on dental procedures to be performed on me/ my family.
- My insurance plan may have a deductible and /or copayment amount which is due at the time of service. I understand that I will be responsible for any other balance **not paid** by my insurance company.
- Any Flex Plan reimbursement will be paid directly to me upon submission of my paid receipt to my company.
- I accept full responsibility for all fees required for my child's/children's dentistry, regardless of my marital status.
- **I understand there is a charge of $100.00 for failing an appointment or canceling without 24 hours notice.**
- In the event that I/my family want to transfer to another office, I understand that my/my family's balance must be paid in full to receive copies of dental records. There is a charge for duplication of X-rays at the request of me or my insurance company.
- I understand that if my check payment is returned NSF from the bank, there is a $25.00 NSF charge which will be added to my account, and I may be asked to make payment by credit card, money order , or cash only.
- I understand that I am responsible for any reasonable fees, expenses, or costs related to the collection of any unpaid balances, including but not limited to late charges, referral costs, and commissions paid to attorneys or collection agencies.

_____

***Patient Signature*** ***Date***

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/ or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

***Please print your name here***

_____

***Signature*** ***Date***

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The Patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgment.

we were not able to communicate with the patient.

Other (Please provide specific details)

_____

_____

_____

*Employee Signature* *Date*