Patient Information:

E-mail _____

Name _____ (First / MI / Last) Age _____ Sex _____ Home Phone ( ) _____

Address _____ Apt. No. _____ Work Phone ( ) _____

City _____ State _____ Zip _____ Other Phone ( ) _____

Birthdate _____ (Month / Day / Year) SSN _____ - _____ - _____ _____ (Drivers License Number) _____ (State)

Employer / Occupation _____ Address _____

In case of emergency, contact: _____ Relationship _____ Phone ( ) _____

Are any of your family members patients of this practice? ☐ YES ☐ NO Name _____ Relationship _____

If the person responsible for the account is different than the patient, please fill in this section:

Name _____ (First / MI / Last) Relationship _____ Home Phone ( ) _____

Address _____ Apt. No. _____ Work Phone ( ) _____

City _____ State _____ Zip _____ Employer _____

Birthdate _____ (Month / Day / Year) SSN _____ - _____ - _____ Address _____

Primary Dental Insurance (Leave blank only if no dental benefits)

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Group No. _____

Policy Number _____

Name of insured if different than patient:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ SS Number _____

Employer _____

Secondary Dental Insurance

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Group No. _____

Policy Number _____

Name of insured if different than patient:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ SS Number _____

Employer _____

Dental History

What is the reason for this appointment? _____

Are there any specific dental problems we should be aware of? _____

Do you think you have any decay or cavities? ☐ YES ☐ NO How often do you brush? _____

Do your gums bleed easily when brushing or flossing? ☐ YES ☐ NO How often do you floss? _____

Do you suffer from chronic bad breath or bad taste? ☐ YES ☐ NO

Do you have any jaw joint cracking or pain? ☐ YES ☐ NO

What was the purpose of your last dental appointment? _____ When was that? _____

When was the last time you had a dental cleaning? _____ Name of previous dentist? _____

When were the last full mouth x-rays taken of your teeth? _____

How would you describe your dental health? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Whom may we thank for referring you to our office? _____

Patient treatment consent

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1½% per month.

Patient / Parent or Guardian Signature: _____ **Date:** _____

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:

	YES	NO
ANY HEART PROBLEMS	☐	☐
HEART MURMUR*	☐	☐
MITRAL VALVE PROLAPSE*	☐	☐
HEART VALVE DEFECT*	☐	☐
HEART VALVE REPLACEMENT*	☐	☐
RHEUMATIC FEVER*	☐	☐
ARTIFICAL JOINT (HIP / KNEE)*	☐	☐
ANGINA	☐	☐
STROKE	☐	☐
HEART ATTACK	☐	☐
BYPASS	☐	☐
PACEMAKER	☐	☐
HIGH BLOOD PRESSURE	☐	☐
LOW BLOOD PRESSURE	☐	☐
ANY BLEEDING DISORDERS	☐	☐
ANEMIA	☐	☐
HEMOPHILIA	☐	☐
SICKLE CELL TRAIT	☐	☐
BLOOD TRANSFUSIONS	☐	☐

	YES	NO
DO YOU SMOKE	☐	☐
LUNG/BREATHING PROBLEMS	☐	☐
ASTHMA	☐	☐
BRONCHITIS	☐	☐
EMPHYSEMA	☐	☐
TUBERCULOSIS	☐	☐
SINUS TROUBLE	☐	☐
DIFFICULTY IN HEALING	☐	☐
DIABETES	☐	☐
THYROID PROBLEMS	☐	☐
ADRENAL/PITUITARY PROBLEMS	☐	☐
LIVER PROBLEMS / DYSFUNCTION	☐	☐
HEPATITIS / JAUNDICE	☐	☐
KIDNEY PROBLEMS / DYSFUNCTION	☐	☐
STOMACH TROUBLE / ULCERS	☐	☐
NERVOUS OR MENTAL DISORDER	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ALCOHOLISM	☐	☐
DRUG ABUSE	☐	☐
DAILY ASPRIN	☐	☐

	YES	NO
ALLERGIC REACTION (HIVES / SWELLING) TO:		
PENICILLIN	☐	☐
ERYTHROMYCIN	☐	☐
SULFA	☐	☐
CODEINE	☐	☐
ASPIRIN	☐	☐
LATEX	☐	☐
LOCAL ANESTHETIC (NOVOCAIN)	☐	☐
OTHER MEDICATIONS OR SUBSTANCES? Please list:	☐	☐
_____		
_____		
CANCER / TUMOR	☐	☐
OTHER GROWTHS	☐	☐
CHEMOTHERAPY / RADIATION THERAPY	☐	☐
SEXUALLY TRANSMITTED DISEASES	☐	☐
OTHER INFECTIOUS DISEASES	☐	☐
HIV / AIDS	☐	☐
ARE YOU PREGNANT?	☐	☐

*Do you need to take antibiotic premedication prior to dental appointments? ☐ YES ☐ NO ☐ DON'T KNOW Name of antibiotic: _____

Do you have any current health problems not noted above? ☐ YES ☐ NO What? _____

Are you currently being treated by a physician? ☐ YES ☐ NO Why? _____

Physician's name, address and phone: _____

Are you presently taking any medications, pills, or tonics? ☐ YES ☐ NO List: _____ For: _____
(i.e., blood pressure, birth control, steroids, hormones) _____ For: _____
_____ For: _____

Is there any condition or problem relating to your medical history that has not been mentioned? ☐ YES ☐ NO Explain: _____

DATE	PATIENT / GUARDIAN SIGNATURE	DOCTOR / HYGIENIST SIGNATURE

Yearly review of Patient Medical History

NO CHANGE	CHANGE	LIST:				
☐	☐	_____	_____	_____	_____	
☐	☐	_____	_____	_____	_____	
☐	☐	_____	_____	_____	_____	
☐	☐	_____	_____	_____	_____	
☐	☐	_____	_____	_____	_____	

Medical Alert Recommended:	YES	NO	DATE:	INTERVIEWER NOTES
1) _____				
2) _____				
3) _____				
Premedication Recommended:	YES	NO		
Rx: _____				

Family and Aesthetic Dentistry

Financial Policy

Thank you for selecting us as your dental health care provider. We are committed to your treatment being a positive experience. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Regarding Insurance

After a complete examination, you will be given **estimates of your planned treatment.** Patients are required to pay the **Estimated Portion** of the fees at the time treatment is rendered. As a **courtesy,** we will accept assignment of insurance benefits.

PLEASE BE AWARE THAT DENTAL INSURANCE COMPANIES DO NOT PAY THE FULL AMOUNT OF EVERY PROCEDURE. WE WILL MAKE EVERY EFFORT TO ESTIMATE YOUR OUT OF POCKET COSTS. ANY UNPAID BALANCE AFTER WE RECEIVE PAYMENT FROM YOUR DENTAL PLAN WILL BE YOUR RESPONSIBILTY.

A few of our patients have the misconception that we know all the details about their insurance. Insurance guidelines have become more and more complicated to understand and control. Please understand filing insurance is a courtesy we extend to our patients. The insurance information we receive is limited, we are not responsible for how your insurance company handles its claims or the benefit amount they will pay. We do not have a contract with your insurance company, only you do. It is your responsibility to understand the coverage and exclusions of your policy.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment, regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor is responsible for the full payment or co payment of insurance on the day treatment is rendered.

Broken or Failed Appointments

Your scheduled appointment time has been reserved at your request. **UNLESS CANCELLATIONS ARE RECEIVED AT LEAST 24 HOURS IN ADVANCE, A $30.00 FEE PER THIRTY MINUTES OF MISSED APPOINTMENT TIME WILL BE CHARGED TO YOUR ACCOUNT.** It is not our intention to charge you; however, we do require this notification to offer this time to another patient. Please help us avoid charging a fee by keeping the appointment that you scheduled.

Payment Options

Payment options include: Cash, Checks, Visa/Master Card/ American Express/ Discover. For you convenience we have established third party financing through Care Credit.
Returned check fee is $35.00.

Delinquent Accounts

Outstanding balances on your account are discouraged. Please keep your account current to avoid any billing fees.

I have read the policy above and understand and agree to the terms as listed.

X_____ **Date**_____

(Signature of patient or responsible party)