

Welcome!

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 Contact 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

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.

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 _____
(NAME OF PATIENT). 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.

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 Urination |
| Y N Claustrophobia | Y N Bells Palsy |
| Y N Artificial Heart Valve | Y N Heart Disease |
| Y N Prolonged Bleeding | Y N Diabetes |
| Y N Ulcers/colitis | Y N Asthma |
| Y N Hay Fever | Y N Night Sweat |
| Y N Head injury | Y N Psychiatric/Emotional |
| Y N Venereal Disease | Y N Recurrent Infections |
| Y N Mitral Valve Prolapse | Y N Angina |
| Y N Acid Reflux | Y N Kidney Problems |
| Y N Arthritis | Y N Bronchitis |
| Y N Epilepsy/seizures | Y N Addictions |
| Y N STD | Y N Pace Maker |
| Y N Rheumatic Fever | Y N Liver Problems |
| Y N Radiation Therapy | Y N Emphysema |
| Y N Stomach Problems | Y N TMJ Problems |
| Y N Glaucoma | Y N Shortness of Breath |
| Y N Dizziness/Fainting spells | Y N Hepatitis: A or B or C |
| Y N Treated for AIDS,HIV, ARC | Y N Tuberculosis |
| Y N Heart Murmur | Y N Unexplained Weight Loss |
| Y N Thyroid Problems | Y N Mouth Ulcers |
| Y N Used Diet Drug Fen-Phen | Y N Aspirin Daily |
| Y N Anemia | |

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 Bleach |
| Y N NSAID (Advil/Motrin) | |
| Y N Gluten | Other _____ |

 Patient or Responsible Party Signature

 Date

 Dentist Signature

 Date

Patient Consent to Receive Mail, E-mail, and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

I agree that the practice may communicate with me electronically at the following address:

Phone Number E-mail Address (*please print*)

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

Send a recall appointment reminder to your home? Y___ N___

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y___ N___

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

Signature of Patient/Parent or Legal Guardian Date

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

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ have received 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 acknowledgment could not be obtained because:

- Patient / Parent or Legal Guardian refused to sign form
- Other

Signature of Office Manager 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 not 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