Patient Information (Confidential)

Name _____ Date _____
First MI Last

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell/Alt _____ Email: _____

Soc. Sec # _____ Birthdate _____ Age _____ Sex: ☐ Male ☐ Female

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Separated ☐ Partnered for _____ years

Patient's or Parent's Occupation _____ Employer/School _____

Business Address _____ City _____ State _____ Zip _____

Work Phone _____ Soc. Sec # _____ Birthdate _____

Spouse or Parent's Name _____ Employer _____

Work Phone _____ Soc. Sec # _____ Birthdate _____

IN CASE OF EMERGENCY, CONTACT: _____ Relationship _____

Phone Number _____ Work Number _____ Cell Phone _____

Alternate person who does not live in your household _____ Phone Number _____

Whom may we thank for referring you? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Employer _____ Work/Cell Phone _____

Birthdate _____ Soc. Sec # _____
Is this person currently a patient in our office? † ☐ YES ☐ NO

Insurance Information

Name of Subscriber #1 _____ Relationship to Patient _____

Employer _____ Insurance Company _____ Group # _____

Birthdate _____ Soc. Sec # _____
Is this person currently a patient in our office? † ☐ YES ☐ NO

DO YOU HAVE ANY ADDITIONAL INSURANCE? † ☐ YES ☐ NO If YES, complete the following:

Name of Subscriber #2 _____ Relationship to Patient _____

Insurance Company _____ Group # _____

Birthdate _____ Soc. Sec # _____
Is this person currently a patient in our office? † ☐ YES ☐ NO

The above questions have been accurately answered. I consent to the dental practice using the above cell phone numbers to call regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

X _____ Date _____
Signature of Patient or Parent if Minor

Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part 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 that you will be receiving. Thank you for answering the following.

Are you in good health? ☐ Y ☐ N

Have there been any changes in your general health in the past year? If YES, explain _____ ☐ Y ☐ N

Are you taking any Medicine(s), include vitamins, herbal, non-prescription medicine(s)? If YES, list _____ ☐ Y ☐ N

Have you ever had surgical operations or serious illness? If YES, list Date(s) and Procedure(s): _____ ☐ Y ☐ N

Have you had any abnormal bleeding? ☐ Y ☐ N

Do you bruise easily? ☐ Y ☐ N

Have you ever required a blood transfusion? Date _____ ☐ Y ☐ N

Have you had a recent abnormal weight loss/gain? ☐ Y ☐ N

Do you or have you used controlled substances (drugs)? ☐ Y ☐ N

Has a physician or previous dentist recommended that you take antibiotics prior to your dental visits?* ☐ Y ☐ N

Are you under the care of a physician? ☐ Y ☐ N

Date of last physical exam _____

Name of Physician _____

City/State _____

Have you ever been hospitalized? ☐ Y ☐ N

Date(s)/Reason(s) _____

Do you have any disease, condition or problem not listed above that you think we should know about? ☐ Y ☐ N

Are you wearing contact lenses? ☐ Y ☐ N

WOMEN ONLY *Are you:*

Pregnant? Number of weeks _____ ☐ Y ☐ N

Nursing? ☐ Y ☐ N

Taking birth control pills or hormone replacement? ☐ Y ☐ N

Are you allergic to or have you had reactions to: (To all 'Yes' responses, specify type of reaction):

Local Anesthetic like Novocaine _____ ☐ Y ☐ N

Penicillin or Other antibiotics _____ ☐ Y ☐ N

Barbiturates, Sedatives, or Sleeping pills _____ ☐ Y ☐ N

Latex/Rubber _____ ☐ Y ☐ N

Any metals _____ ☐ Y ☐ N

Aspirin _____ ☐ Y ☐ N

Codeine or other narcotics _____ ☐ Y ☐ N

Other (Please List) _____ ☐ Y ☐ N

Place a mark (X) on "Y"(YES), "N"(NO) or "DK" (Don't Know) to indicate if you currently have or had any of the following diseases or problems:

	Y	*N*	*DK*
Autoimmune, AIDS/HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis, Rheumatism	☐	☐	☐
Artificial/Damaged Heart Valves*	☐	☐	☐
Asthma	☐	☐	☐
Artificial (Prosthetic) Joints*, *Date(s) placed*_____	☐	☐	☐
Back Problems	☐	☐	☐
Cancer, *Type*_____	☐	☐	☐
Chemical Dependency	☐	☐	☐
Chemo/Radiation Treatment Date(s) _____	☐	☐	☐
Circulatory Problem/ Arteriosclerosis	☐	☐	☐
Cold sores/Fever Blisters	☐	☐	☐
Congenital Heart Disease*	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Cough, persistent or bloody	☐	☐	☐
Cortisone treatment, *Type* _____	☐	☐	☐
Diabetes Type I or Type II	☐	☐	☐
Epilepsy or Seizures *Frequency* _____	☐	☐	☐
Emphysema	☐	☐	☐
Fainting/Dizzy Spells	☐	☐	☐
Glaucoma	☐	☐	☐
Jaundice, Liver Disease	☐	☐	☐
Hepatitis, *Type* _____	☐	☐	☐
High/Low Blood Pressure	☐	☐	☐
Hypercholesterol	☐	☐	☐
Heart Murmur or Defect	☐	☐	☐
Kidney Disease	☐	☐	☐
Previous Infective endocarditis*	☐	☐	☐
Heart Attack Date(s) _____	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Osteoporosis:	☐	☐	☐
On medication?	☐	☐	☐
On IV bisphosphonates?	☐	☐	☐
Pacemaker *Date placed* _____	☐	☐	☐
Nervous Problem	☐	☐	☐
Psychiatric Care	☐	☐	☐
Respiratory Disease	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Shortness of Breath	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sleep Disorder	☐	☐	☐
Systemic Lupus Erythematosus	☐	☐	☐
Skin Rash/Hives	☐	☐	☐
Special Diet	☐	☐	☐
Stroke, *Date*_____	☐	☐	☐
Swollen Feet or Ankles	☐	☐	☐
Swollen Neck Glands	☐	☐	☐
Thyroid Problems	☐	☐	☐
Tonsillitis	☐	☐	☐
Tumor or Growth on head/neck	☐	☐	☐
Tuberculosis	☐	☐	☐
Stomach Ulcer/GERD	☐	☐	☐
Veneral Disease/STD	☐	☐	☐
Bleeding Abnormally	☐	☐	☐
Blood Disease	☐	☐	☐

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ Date _____

Signature of Patient or Parent if Minor

Doctor's Comments: BP _____/_____ Pulse _____ Date _____

Doctor's Initial _____

Patient Dental History

Reason for Today's visit _____

Date of last dental visit _____ Reason for visit _____

Former Dentist _____ City/State _____

Date of last dental exam/x-rays _____ Date of last dental cleaning _____

Place a mark on "Y" (YES) or "N" (NO) to indicate if you currently have the following. Check "DK" if you Don't Know the answer to the question:

	Y	N	DK
Do your gums bleed while brushing or flossing?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Are your teeth sensitive to hot, cold, sweets or pressure?	☐	☐	☐
Do you have any broken crowns or fillings?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
If YES, explain _____			
Have you ever experienced any of the following problems in your jaw:			
Clicking or popping or discomfort in the jaw	☐	☐	☐
Earaches or neck pains	☐	☐	☐
Difficulty in opening or closing	☐	☐	☐
Difficulty in chewing	☐	☐	☐
Jaw pain or tiredness	☐	☐	☐
Do you wear an occlusal/night guard or splint?	☐	☐	☐
Do you have frequent headaches or migraines?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Do you bite you lips or cheeks frequently?	☐	☐	☐
Have you ever had Jaw Surgery?	☐	☐	☐

	Y	N	DK
Have you ever whitened your teeth?	☐	☐	☐
Does food collect between your teeth?	☐	☐	☐
Have you noticed any loosening of teeth?	☐	☐	☐
Do you have bad breath?	☐	☐	☐
Have you ever had GumTreatment/Surgery?	☐	☐	☐
If YES, when _____			
Do you wear Partials or Dentures?	☐	☐	☐
If YES, date of placement: _____			
Do you have any sores /ulcers in or near your mouth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Do you have burning sensation on tongue?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)	☐	☐	☐
How much?_____How long?_____			
If yes, how interested are you in stopping?	☐	☐	☐
Do you drink alcohol beverages?	☐	☐	☐
Have you ever had Orthodontic Treatment?	☐	☐	☐
Are you currently in braces/Orthodontic Treatment?	☐	☐	☐
Do you wear a retainer?	☐	☐	☐

Have you had problems associated with previous dental treatment? _____

How do you feel about your teeth and your smile? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the dentist(s) to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of Patient or Parent if Minor

Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____ , have read the Dental Material Fact Sheets. (A copy can be requested)

Print Name or Parent if Minor

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X _____ Date _____

Signature of Patient or Parent if Minor

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ , have read this office's Notice of Privacy Practices. (A copy can be requested)

Print Name or Parent if Minor

X _____ Date _____

Signature of Patient or Parent if Minor

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:

☐ Individual refuse to sign ☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (Please Specify) _____

X _____ Date _____

Signature of Dentist

Financial Agreement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. In order to achieve this goal we are providing you with a statement of our Financial Agreement to assist in understanding our payment policies.

Payment is due at the time services are rendered
We accept cash, checks, Visa/MC/Discover
We offer financing through CareCredit. If you are interested, please let us know

Commercial Insurance: As a courtesy to our patients we will gladly file your insurance claim for you for the treatment provided. Insurance benefits are determined by the insurance company and the employer; we are not a party to that contract. Please refer to your benefits policy for explanations on copays and deductibles and for excluded treatment. We are currently an in- network provider with Delta Premier and Cigna Radius; all other insurances will be filed as out-of- network. Please be aware that some services provided may not be covered by your insurance plan. If your insurance plan reimburses you then payment is due at the time of service.

Co-pays: All co-pays and deductibles are due at the time of service. We accept cash, check, Visa, MC, Discover and CareCredit for those payments. We try to maintain accurate records for those co-pays, however, since they are only and estimate there may be a balance due after the insurance payments have been received.

Collection Responsibility Notice Policy: In consideration of the services provided to the patient, all balances on the patient account are due within 30-days. After completion of treatment accounts over 90-days past due will be charged a 1.5% finance charge. Severely delinquent accounts may be sent to collections.

Minor Patients: The parents or guardians of the minor are responsible for full payment. For divorced parents: The parent who brings the patient to his/her appointment is responsible for any payment due the day of service. We cannot bill former spouses or do split billing.

Missed Appointments/Cancellations/Late Arrival: Our office **requires 48-business hour's notice of change or cancellation of appointments.**

We understand that unforeseeable circumstances or illness can occur and we will handle each case of missed appointments on an individual basis. **We do however reserve the right to charge for missed appointments.** (ranging from $25-$100 dependent on the patients history of, and/or, length of missed appointment)

Late arrivals – if you arrive later than 15 minutes late, we will need to reschedule your appointment to ensure quality care for you and the patients scheduled after you.

We recognize that financial concerns may arise and we want to reassure you that we will be happy to assist you in managing your account. Thank you for understanding our financial agreement.

I have read and agree to this Financial Agreement

_____ _____

Signature of Responsible Party **Date**