Welcome to our office!

To serve you the best, please provide the following information – all information is confidential.

Patient Information

Patient Name: ____ **Date:** __________
Last, First MI (Preferred Name)

Social Security #: __________ **Driver's License #:** ______________ **Birth Date:** __________

Phone (Home): ____________ **(Work):** ____________ **(Mobile) Phone:** ______________

Email Address: ____

Address: ____
Street Apartment #

____
City State Zip Code

☐ Male
☐ Female
☐ Single
☐ Married
☐ Child

Employer Name: ____________________ **Occupation:** ______________

Employer Address: ____
Street City, State Zip Code

Emergency Contact Information: ______________________________________
Name Phone Number

Please check the cable TV channels you prefer to watch:
☐ *CNN* ☐ *FOX* ☐ *Discovery* ☐ *Food Network* ☐ *Local News* ☐ *ESPN* ☐ *Other* _________

Dental History

What is the reason for your visit today? ______________________________________

How do you feel about visiting the Dentist? ____________________________________

Date of last dental exam: ___________ **Date of last dental cleaning:** __________

Have you ever had any complications with dental treatment? ☐ Yes ☐ No

If yes, please explain: ____

If you could change your smile, what would you change?

☐ Straight teeth ☐ Whiter teeth ☐ Close gaps between teeth ☐ Replace missing teeth ☐ Worn teeth
☐ More youthful smile ☐ Replace metal fillings with tooth colored fillings ☐ Restore broken teeth

Do you have any of these concerns:

☐ Bad breath ☐ Cold Sores ☐ Bleeding Gums ☐ Morning headaches ☐ Jaw joint pain
☐ Teeth grinding / clenching ☐ Athletic Sports guard ☐ Receding Gumline ☐ Dry Mouth

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient, friend ☐ Another patient, relative ☐ Insurance Provider List ☐ Yellow Pages
☐ Postcard ☐ School ☐ Work ☐ Other ______________________________________

Name of person or office referring you to our practice: ______________________________

Patient Name: ______________________________________ Birth Date: ____________

Last, First MI

Responsible Party Information

(if different from patient)

Name: ______________________________________

Social Security #: __________ **Driver's License #:** ____________ **Birth Date:** _

Relationship to the patient: __________________________

Phone (Home): ____________ **(Work):** ______________ **Mobile Phone:** ________

Address: ______________________________________

Street Apartment #

____

City State Zip Code

Insurance Information

Name of Insured: ______________________________ **Is insured a patient?** ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ **ID #:** ______________ **Group #:** __________

Insured's Address: ______________________________________

Street City State Zip Code

Insured's Employer Name: ______________________________________

Address: ______________________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________________

____

Health Information

Have your ever had any of the following? Please check those that apply:

Yes/No		Yes/No		Yes/No	
☐ ☐	Heart Disease / Attack	☐ ☐	Metal / Jewelry allergy	☐ ☐	Nervous Disorders
☐ ☐	Heart Murmur	☐ ☐	Stroke	☐ ☐	Epilepsy / Seizures
☐ ☐	Mitral Valve Prolapse	☐ ☐	Hepatitis	☐ ☐	Fainting
☐ ☐	High Blood Pressure	☐ ☐	HIV / AIDS	☐ ☐	Glaucoma
☐ ☐	Artificial Heart Valve	☐ ☐	Tuberculosis	☐ ☐	Radiation Treatment
☐ ☐	Birth Heart Defect	☐ ☐	Kidney Disease	☐ ☐	Sinus Problems
☐ ☐	Heart Surgery	☐ ☐	Liver Disease	☐ ☐	Asthma
☐ ☐	Rheumatic Fever	☐ ☐	Head Injuries	☐ ☐	Diabetes
☐ ☐	Artificial Joints	☐ ☐	Bleeding / Clotting Problems	☐ ☐	Cigarette Smoking
☐ ☐	Penicillin Allergy	☐ ☐	Respiratory Problems	☐ ☐	Chewing Tobacco
☐ ☐	Latex Allergy	☐ ☐	Cancer	☐ ☐	Anemia
☐ ☐	Other Allergies:	☐ ☐	Jaundice	☐ ☐	**Pregnancy**
☐ ☐	______________	☐ ☐	Stomach Problems		Due date:________
☐ ☐	______________	☐ ☐	Arthritis		

- **Do you have any health problems or conditions or diseases that are not listed above?** ☐ **Yes** ☐ **No**

  If yes, please explain: ______________________________________

- **Name of Physician:** ______________________________ **Phone:** __________
- **Please list all medications you are currently taking including all over the counter products:** ________

____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor before treatment.

____

Signature of patient, parent or guardian Date Signature of the Doctor

Patient Name: ______________________________ Birth Date: ____________
Last, First MI

Office Policies

Financial Policy Agreement

- ☐ Payment is expected at the time when services are provided. If you have insurance, the estimated patient portion of the fee is due at the time of service. Any other payment arrangement must be made in advance of services.
- ☐ We allow extra time for the insurance company to pay their estimated portion.
- ☐ If the insurance company has not fully paid a claim after a reasonable period of time, (usually 30 days) you will be required to pay that remaining portion.
- ☐ As a courtesy, we are happy to verify your benefits and bill your insurance. Information received is not a guarantee of benefits or payment from the insurance company, we use this information to estimate as closely as possible your insurance coverage.

- ☐ I understand that any costs incurred during treatment are my responsibility. I realize that insurance may help pay part of my treatment and that the estimates quoted to me are only *estimates*. I will be responsible for any fees unpaid by the insurance company. I understand that there may be monthly interest (1.5%) applied to the balance, and any additional costs of collection will be applied to the balance.

Cancellation Policy Agreement

- ☐ I understand that if I fail to give 24 hours notice to cancel a scheduled appointment, that I may be charged a fee up to the amount of the scheduled appointment procedure.

Notice of Privacy Practices Acknowledgement

- ☐ Under the *Health Insurance Portability & Accountability Act of 1996* (HIPAA) I have certain rights to privacy regarding my protected health information. This information is used to conduct to your treatment, obtain payment from third party payers, and other various uses. I acknowledge that I have received your *Notice of Privacy Practices* containing a complete description of the uses of my health information and how I may restrict the use of this information.

Consent for Treatment

- ☐ I give consent for dental treatment by the doctor and staff.
- ☐ I understand that with each procedure there are particular risks and benefits. Possible risks for even routine treatment (such as fillings, crowns, root canals, and extractions) can be sensitive teeth, infection, paresthesia, traumatized pulp (nerve). Additional procedures may be required to treat any further complication.
- ☐ The practice of dentistry is not an exact science, and although we strive to give best care possible, guarantees can not be made concerning the results of the treatment.
- ☐ I consent to the use of local anesthetics, antibiotics, nitrous oxide (laughing gas), and analgesics (pain medications) as needed to complete treatment.
- ☐ I understand that I may ask questions at any time regarding the risks and benefits and alternatives for any recommended treatment.

______________________________ ____________ ______________
Signature of patient, parent or guardian | Date | Relationship to Patient

______________________________ ____________ ______________
Signature of guarantor of payment/responsible party | Date | Relationship to Patient