

Welcome to Our Practice

Patient Information (Confidential)

| | | | | |
|---|--|--|-------------------|-------------------|
| Last Name | First Name | Nickname/Call by | Birth date / / | Social Security # |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced | | Employer | |
| Home Address | | | City | State Zip |
| Home Phone () | Work Phone () | Email (<i>would you like to communicate with us via email</i>) Yes No | | |
| Cell Phone () | How did you hear about our office? If you were referred, whom may we thank for referring you? | | | |

Responsible Party to Pay for Services

Relationship to Patient Self Spouse Parent

| | | | |
|---|--|---|-------------------|
| Responsible Party Last Name | First Name | Birth Date / / | Social Security # |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced | | Employer |
| Home Address | | | City State Zip |
| Home Phone () | Work Phone () | Is this person currently a patient in our office? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Insurance Information

| | | |
|--|-------------------|------------------------|
| Name of Insured | Birth Date / / | Subscriber ID# |
| Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other | Employer | |
| Insurance Company | Group Number | Insurance Phone () |

Office Policy and Financial Agreement

1. Payment in full or validated insurance coverage along with estimated co-payment is due at the time of service.
2. As a service to our patients, we will bill your insurance company. If your insurance company fails to pay any outstanding balance, then payment in full is the responsibility of the insured or person responsible for the account.
3. Arrangements for payment other than payment in full or insurance must be made prior to appointments.
4. Balances over 60 days past due will be subject to a finance charge of 1.5% per month (18% APR). Accounts over 90 days past due will be forwarded to collections.
5. There will be a \$25 charge for each returned check.
6. We ask that **24-hour notice** be given for any cancellation of appointments so that we may fill in that time with someone else who desires to have treatment. There will be a **\$50 charge per hour** for broken appointments or cancellations without 24 hour notice.

Informed consent disclosure, assignment and release of information:

If I consent and elect to proceed with treatment, I hereby authorize my insurance benefits to be paid directly to the dentist and understand that I am financially responsible for services not insured. I further authorize the dentist to release any medical or dental information or other records, including x-rays, necessary in the conduct and disposition of my case.

Signature of patient or legal guardian

Date

Patients Name:

Dental History

Reason for today's visit? _____

Former Dentist: _____ Date of Last Cleaning: _____

Date of Last Dental Visit _____ Reason for Changing Dentist _____

Have you had any problems with previous dental treatment? _____

Are you nervous about seeing a dentist? (If yes, explain) _____

Check if you have had any of the following?

- Clicking or popping jaw Periodontal surgery Sensitivity to cold Sensitivity when biting
- Pain in the jaw joint Deep cleaning Sensitivity to heat Facial or jaw injury
- Grinding or clenching Orthodontic treatment Sensitivity to sweets Other _____

How often do you brush? _____ How often do you floss? _____

Are you happy with the appearance of your teeth/smile? Yes No If no, explain: _____

What are your dental priorities? Check all that apply:

- Comprehensive dental care Improve the appearance of my teeth (e.g. whitening)
- Emergency dental care Other, please specify

Medical History

Physician's Name: _____ Physician's Phone: _____ Date of last visit _____

Have you had any serious illnesses or operations? Yes No

If yes, describe: _____

Are you currently under physician care? Yes No If yes, describe: _____

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Do you smoke? Yes No How much? _____ Do you use chewing tobacco? Yes No

Check Yes or No for each of the following:

- | | | | |
|---|---|--|--|
| Yes/No | Yes/No | Yes/No | Yes/No |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis, type? _____ | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> HIV positive/AIDS |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes, type? _____ | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Immune disorder |
| <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Cancer, type? _____ | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Tumor or malignancy | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Jaundice or liver disease |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Arthritis/Rheumatism |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Respiratory/lung disease | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or seizure | <input type="checkbox"/> Anemia/blood disorder | <input type="checkbox"/> Epilepsy or seizure |
| <input type="checkbox"/> Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®) | | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Kidney disease |
| | | <input type="checkbox"/> Have you ever taken diet pills such as Fen Phen and Redux | |

List all your **CURRENT MEDICATIONS** or **Supplements**:

Check if you are **ALLERGIC** to any of the following:

- Penicillin Sulfa Drugs
- Latex Aspirin
- Codeine Local Anesthetic
- Other, _____

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. **If I ever have any changes in my health, or medications, I will inform the dentist and his/her staff at my next appointment.**

Signature of patient or legal guardian

Date

Signature of Doctor

Date