CONFIDENTIAL

PLEASE FILL OUT ALL SIDES OF THIS FORM COMPLETELY. THE INFORMATION YOU PROVIDE WILL HELP US SERVE YOUR DENTAL HEALTHCARE NEEDS. IF YOU HAVE ANY QUESTIONS, PLEASE ASK US. WE ARE ALWAYS HAPPY TO HELP.

PATIENT INFORMATION

(PLEASE PRINT) DATE_____

NAME_____NICKNAME, IF PREFERRED_____
Last *First* *MI*

BIRTHDATE_____SOCIAL SECURITY #_____EMAIL _____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

DO YOU PREFER TO BE CONTACTED AT: ☐ HOME ☐ WORK ☐ CELL ☐ NO PREFERENCE

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR
PARENT/GUARDIAN'S EMPLOYER_____OCCUPATION_____

SPOUSE OR
PARENT/GUARDIAN'S NAME_____EMPLOYER_____WORK PHONE_____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE_____CITY_____STATE_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY_____PHONE_____

RESPONSIBLE PARTY

(IF DIFFERENT FROM ABOVE INFORMATION)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP TO PATIENT_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

BIRTHDATE_____SOCIAL SECURITY #_____EMPLOYER_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

DENTAL INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD(S) TO COPY FOR OUR RECORDS

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SOCIAL SECURITY #_____INSURANCE ID #_____

NAME OF EMPLOYER_____WORK PHONE_____

INSURANCE COMPANY_____GROUP #_____UNION OR LOCAL #_____

BENEFIT YEAR_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SOCIAL SECURITY #_____INSURANCE ID #_____

NAME OF EMPLOYER_____WORK PHONE_____

INSURANCE COMPANY_____GROUP #_____UNION OR LOCAL #_____

BENEFIT YEAR_____

PLEASE CONTINUE ON THE REVERSE SIDE

FINANCIAL OPTIONS

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements, please ask for assistance.

NO DENTAL INSURANCE:

☐ **PAYMENT IN FULL AT TIME OF SERVICES - CASH/CHECK/CREDIT CARD (VISA OR MASTERCARD) (Discount Applies)**

DENTAL INSURANCE:

☐ **PAYMENT IN FULL AT TIME OF SERVICES BY CASH/CHECK/CREDIT CARD; INSURANCE BENEFITS REIMBURSED TO YOU - (Discount Applies)**

☐ **PAYMENT IN FULL OF CO-INSURANCE AT TIME OF SERVICES WITH INSURANCE BENEFITS ASSIGNED TO DOCTOR. UPON RECEIPT OF THE FIRST MONTHLY STATEMENT AFTER INSURANCE BENEFITS HAVE BEEN RECEIVED, PAYMENT IN FULL OF ANY REMAINING BALANCE - (Discount Does Not Apply)**

THIRD PARTY FINANCING (CAPITAL ONE) MAY BE AVAILABLE AND CAN BE ARRANGED THROUGH OUR OFFICE

OFFICE POLICIES

FINANCE CHARGES:
If I do not pay the balance due in full within 60 days, I understand that a finance charge of 1.5% on the unpaid balance will be assessed each month.

APPOINTMENT CANCELLATION:
I understand that failure to appear for a scheduled appointment and/or failure to give 24 hours notice for any appointment changes will result in a $35.00 fee for which I am responsible.

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than any pre-estimated amounts and/or less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

SIGNATURE_____**DATE**_____
Signature of patient or parent/guardian if minor

To the best of my knowledge, the above questions have been accurately answered. Further, I certify that I have read, understand, and agree to all information and policies provided.

SIGNATURE_____**DATE**_____

PLEASE COMPLETE THE DENTAL AND MEDICAL HISTORY ON THE FOLLOWING PAGES

DENTAL HISTORY

NAME_____

Are you having dental pain? YES___ NO___

Do you have toothaches? YES___ NO___

Are your teeth sensitive to hot___, cold___, sweets___? YES___ NO___

Are your teeth affecting your general health? YES___ NO___

Ever had trouble with previous dental treatment? YES___ NO___

Ever had an adverse reaction to:

Penicillin - Yes___No___ Novocaine - Yes___ No___ Latex - Yes___ No___

Codeine Medications - Yes___No___ Anesthetics or Gas - Yes___ No___

Metals - Yes___ No___ Acrylics - Yes___ No___

Are your gums frequently sore/tender? YES___ NO___

Do your gums bleed easily? YES___ NO___

Ever been told you have gum disease? YES___ NO___

Ever worn braces? YES___ NO___

Ever had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or lips? YES___ NO___

Ever had a serious injury to your face or jaws? YES___ NO___

Ever had difficulty with extractions or other operations such as:

Excessive Bleeding - Yes___ No___ Swelling - Yes___ No___

Infection - Yes___ No___ Complications - Yes___ No___

Do you experience popping, clicking or soreness of the jaw joints (just in front of the ears)? YES___ NO___

Do you clench or grind your teeth:

When Awake - Yes___ No___ While Sleeping - Yes___ No___

Are you dissatisfied with the appearance of your teeth? YES___ NO___

Have you whitened your teeth? YES___ NO___

Have you been instructed on proper home care of your teeth and gums including the use of dental floss and the importance of using antiseptic mouth rinses regularly? YES___ NO___

Were you satisfied with your prior dental treatment/dentist? YES___ NO___

When was your last dental visit? _____

What was done? _____

Has fear kept you from seeking dental treatment? YES___ NO___

Do you wish to avoid dentures? YES___ NO___

If you have dentures, are you satisfied with them? YES___ NO___

Do you use tobacco? YES___ NO___

PLEASE COMPLETE THE MEDICAL HISTORY ON THE REVERSE SIDE

MEDICAL HISTORY

DATE_____

Do you have, or have you had any of the following? Please indicate with a ✓

___Heart Problems
___High Blood Pressure
___Low Blood Pressure
___Mitral Valve Prolapse
___Heart Murmur
___Angina
___Pacemaker
___Circulatory Problems
___Excessive Bleeding
___Rheumatic Fever
___Joint Replacement
___Stroke
___Artificial Heart Valve
___Taken Phen-Fen or Redux
___Tuberculosis
___Allergies to Anesthetics
___Allergies to Medicines
___Allergies to _____
___Arthritis
___Asthma
___Ulcer/Stomach Trouble
___GERD
___Tonsillitis
___Nervous Problems
___Anemia
___Cold Sores
___Pregnant: Due_____
___Emphysema/COPD
___Seizures/Fainting
___HIV/AIDS
___Hepatitis/Jaundice
Type_____
___Diabetes:
Type_____
___Cancer/Malignancies/Tumors
___Radiation Treatment
___Leukemia
___Thyroid Problems
___Sinus Problems
___Psychiatric Care

CURRENT MEDICATION(S)	REASON FOR USE

Please indicate any current medical conditions, treatment, health history or any other information that may affect your dental treatment.