WELCOME!

1. PATIENT INFORMATION

Date:

Last Name _____ First Name _____ MI _____

Sex ☐ Male ☐ Female Soc. Sec. # _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State _____ Zip Code _____

Email _____ Cell Phone _____ Home Phone _____

Employer _____ Work Phone _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone # _____

If under 18, Name of Parent _____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone _____

Pharmacy Name _____ Pharmacy Address _____

Reason for today's visit? _____

How did you hear about us? ☐ Internet/Online ☐ Drive By/Walk-In ☐ Family/Friend ☐ Insurance ☐ School Event ☐ Social Media ☐ Mailer

2. DENTAL INSURANCE INFORMATION *(Primary Carrier)*

Policy Holder's Name _____

Policy Holder's Employer _____

Policy Holder's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

3. DENTAL INSURANCE INFORMATION *(Secondary Carrier)*

Policy Holder's Name _____

Policy Holder's Employer _____

Policy Holder's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

4. MEDICAL INSURANCE INFORMATION

Policy Holder's Name _____

Policy Holder's Employer _____

Policy Holder's DOB _____

Insurance Co _____

Member ID # _____

Group # _____ Insurance Phone # _____

5. FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards, or one of the third-party financing options we provide.

☐ **Please check if you would like more information about financing options.**

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, credit card or one of the third-party financing options we provide.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

HIPAA and Financial Consent

We understand that medical information about you and your health is personal, and we are committed to protecting such information. For a detailed description of our privacy practices, please see our "Notice of Privacy Practices" at the front desk. This document also describes your rights and certain obligations we have regarding the use and disclosure of medical information. Other uses and disclosures of medical information not covered by this Notice, will be made only with your written permission.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges.

_____ _____

Patient Signature/Legal Guardian *Date*

6. DENTAL HISTORY Please mark (x) on any of the following conditions that apply to you

Patient Name (print):

Appearance
- ☐ Discolored teeth
- ☐ Flat/worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Crowding
- ☐ Spaces/missing teeth
- ☐ Deep bite

Pain/Discomfort
- ☐ Sensitivity (hot, cold, sweets)
- ☐ Pressure/pain with chewing
- ☐ Broken teeth/fillings
- ☐ Dry mouth
- ☐ Other: _____

Function
- ☐ Grinding/clenching
- ☐ Morning headaches
- ☐ Jaw joint (TMJ) pain
- ☐ Jaw joint (TMJ) clicking/popping
- ☐ Speech impediment
- ☐ Mouth breathing
- ☐ Sore muscles (head, neck)
- ☐ Difficulty opening or closing
- ☐ Difficulty chewing on either side

Periodontal (Gum) Health
- ☐ Bleeding, swollen, irritated gums
- ☐ Bad breath
- ☐ Loose, tipped or shifting teeth
- ☐ Previous perio/gum disease

Sleep Pattern or Conditions
- ☐ Sleep apnea
- ☐ Snoring

Habits
- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/lip biting
- ☐ Chewing on ice/foreign objects

Social

Tobacco packs per day _____

Alcohol frequency _____

Drugs frequency _____

Previous Comfort Options
- ☐ Nitrous oxide
- ☐ Oral sedation (pill)
- ☐ IV sedation

Frequent/Daily Use:
- ☐ Soda/sweet tea
- ☐ Coffee with creamer/sugar
- ☐ Sports/energy drinks
- ☐ Candy/sweets
- ☐ High carb diet

Please share the following dates: Your last dental visit _____ Your last cleaning _____

What is the most important thing to you about your dental visit today? _____

_____

On a scale of 1-10, with 10 being the highest rating: Dental Anxiety 1 2 3 4 5 6 7 8 9 10 Happy with your smile 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile? ☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth ☐ Teeth Sensitive to hot, cold, sweets or pressure ☐ Other

7. MEDICAL HISTORY Please mark (x) as your response to indicate if you have or have had any of the following

Medical Allergies
- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local anesthetics
- ☐ NSAIDs

Other allergies/comments

_____

_____

_____

Cancer

Type _____
- ☐ Chemotherapy
- ☐ Radiation therapy

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Heart conditions
- ☐ Heart surgery
- ☐ High/low blood pressure
- ☐ Pacemaker
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease

Gastrointestinal
- ☐ Reflux
- ☐ Gastrointestinal disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood disorders
- ☐ Bruise easily
- ☐ Excessive bleeding

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness/fainting
- ☐ Drug/alcohol addiction
- ☐ Seizures
- ☐ Psychiatric illness

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Respiratory problems
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV positive
- ☐ HPV
- ☐ Cold sores

Women
- ☐ Currently pregnant Due date: _____
- ☐ Nursing

Are you under the care of a physician? If yes, please explain _____

Physician Full Name _____ Phone _____

Have you had a serious illness, operation, or hospitalization in the past 5 years? If yes please explain _____

_____

Please circle if you have any of these conditions: Artificial Heart Valve Previous Infective Endocarditis Damaged Heart Valves in Heart Transplant Unrepaired Cyanotic CHD Repaired CHD with Residual Defects

Please list medications currently taking: _____

_____

Have you ever in the past, or are you now currently taking, any medications for Osteopenia/Osteoporosis or Bone Disease? If yes, please list medications:

_____

Are you on blood thinners? If yes, please list: _____

Consent:

I hereby authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

_____ _____ _____

Signature of Patient/Legal Guardian *Print Name* *Date*

_____

Dentist/Hygienist Signature