Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

In Case of Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom can we thank for referring you to us? _____

Account Information

☐ Person responsible for this account is the same as above

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

☐ Additional Insurance

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all infomation necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** _____ Date: _____

Medical History

Although our Dental Team primarily treats areas in and around your mouth the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible, Thank You!

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain:_____

_____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain:_____

_____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain:_____

Have you ever taken, Phen-Fen, Redux, Fosamax? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No If yes, please explain:_____

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain:_____

Please list any medications, pills, or drugs you are taking: _____

_____

Women:

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Renal Dialysis	☐ Other Serious Illness
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A,B, or C	☐ Rheumatic Fever	Please Explain: _____
☐ Anaphylaxis	☐ Drug Addiction	☐ Headaches	☐ Rheumatism	_____
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever	_____
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Shingles	_____
☐ Arthritis / Gout	☐ Epilepy or Siezures	☐ Hives or Rash	☐ Sickle Cell Disease	_____
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble	_____
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida	_____
☐ Asthma	☐ Fainting Spells / Dizziness	☐ Kidney Problems	☐ Stomach Disease	_____
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Intestinal Disease	_____
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Stroke	_____
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs	_____
☐ Bruise easily	☐ Genital Herpes	☐ Lung Disease	☐ Thyroid Disease	_____
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Problems	☐ Tonsilitis	_____
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tuberculosis	_____
☐ Chest Pains	☐ Heart Attack / Failure	☐ Parathyroid Disease	☐ Tumors or Growths	_____
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	☐ Ulcers	_____
☐ Congenital Heart Disease	☐ Heart Pace Maker	☐ Radiation Treatments	☐ Venereal Disease	_____
☐ Convulsions	☐ Heart Trouble / Disease	☐ Recent Weight Loss	☐ Yellow Jaundice	_____

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health I will not hold my Dentist or any members of his/her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X** _____ Date: _____

Insurance & Financial Policy

Our goal in discussing financial arrangements relative to your dental needs includes:

- to inform you of treatment alternatives
- their respective advantages and disadvantages
- the consequences and/or risks of limited delayed treatment and/or non-treatment

> Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.

> Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a predetermined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which your insurance agreement allows. However, this should not have control over what is in your best interest as far as treatment is concerned.

> For your convenience, we will estimate the portion of the fee that your insurance company will not cover. This is just an estimate. After your insurance benefits have been paid, you are responsible for any unpaid balance. We will ask you to bring with you at the time of treatment the estimated uncovered portion of the total fee.

> It is not possible to know exactly what your insurance coverage will be prior to treatment, as treatment sometimes changes. We can predetermine your benefits with your insurance company; however, this delays treatment 4-6 weeks or longer, waiting for the insurance company to respond, which may not be in the best interest of your oral health.

> A finance charge of 1-1 1/2% will be added to your bill if payment has not been received within 60 days. This will allow adequate time for your to ensure that your insurance benefits have been paid to your satisfaction.

> Should collections become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and courts costs.

> Our policy, and most dental plans, require a percentage fee, (co-payment) to be paid at the time of your treatment. Full payment is required at the time of service if you are not covered by a dental plan.

Payment Options:

- Cash
- Check
- Visa, Mastercard, Discover

I authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay an uncovered balance. I hereby authorize release of information for insurance purposes.

Signature of Patient (or Guardian) _____ Date _____