

ABOUT YOUName: _____
Name MI LastPreferred name: _____
Home Address: _____
City State ZipSocial Security #: _____
Driver's License # _____Date of Birth: _____ Age _____ Male Female
 Single Married Divorced WidowedName of spouse: _____
Your Employer: _____Occupation: _____ How long? _____
Email Address: _____Whom may we thank for referring you to our office?
_____**Who is responsible for this account?**
 Self Spouse Parent Other _____**TELEPHONE INFORMATION**Best phone # to reach you: _____
Alternate phone #: _____In the event of an emergency, is there someone we can contact? YES NOName: _____
Relationship: _____

Phone #: _____

CANCELLATION POLICY
EXCEPT IN SEVERE WEATHER
CONDITIONS OR IN EXTREME
EMERGENCIES, A 48 HOUR NOTICE IS
REQUIRED FOR CANCELLATION.
OTHERWISE, PATIENTS WILL BE
RESPONSIBLE FOR PAYMENT
FOR THEIR APPOINTMENT, WHICH WILL
BE CHARGED AT THE RATE OF
\$50 PER 1/2 HOUR.
SIGNATURE: _____

STATEMENT OF PAYMENT POLICY

Payment is required for all charges on the day of service. As a courtesy, we will bill your insurance company for their estimated portion, if we are provided with a copy of your insurance card. If we do not receive payment from your insurance company for their portion within 60 days we will send you a statement and expect payment in full from you at this time. Any balance over 90 days is subject to an 18% finance charge.

SIGNATURE: _____**DENTAL BENEFITS**Do you have dental benefits?
 YES NO

If yes, please provide us the following information:

Name of Subscriber: _____

Date of Birth: _____

Social Security or ID #: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: _____

Group #: _____

Employer's Name: _____

Employer's Phone #: _____

Employer's Address: _____

City State Zip

INSURANCE COVERAGE

Every effort is made to provide you with the best estimate from your insurance company. In some cases, actual insurance payments are lower than the estimates given. Charges incurred are ultimately your responsibility and you will be responsible for any difference in the insurance estimate and actual insurance payment.

SIGNATURE: _____**RELEASE OF INFORMATION**

I hereby authorize the release of any dental information necessary to process my dental claims.

SIGNATURE: _____**ASSIGNMENT OF BENEFITS**

I hereby authorize for payment from my dental insurance to be made directly to my dentist.

SIGNATURE: _____**PHOTOGRAPHY RELEASE**

I hereby give Willow Springs Dental permission to use my likeness and photographs of my dental treatment in a professional manner for promotional and educational purposes, i.e. posters, video prostrations, etc. as they see fit.

SIGNATURE: _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my insurance information, address or phone number.

SIGNATURE: _____

WILLOW SPRINGS DENTAL

MEDICAL HISTORY

Physician's Name: _____

Phone #: _____ Last medical visit: _____

Are you currently under the care of a physician? YES NO

If yes, explain: _____

Do you smoke or chew tobacco? YES NO

Do you drink alcohol? YES NO How often? _____

Are you currently taking any drugs prescribed by a physician or dentist? YES NO

If yes, please list: _____

Have you ever taken Phen Phen? YES NO

For women: Are you pregnant? YES NO

If yes, how many months? _____

Have you had any prior surgeries? YES NO

If yes, please list: _____

Do you need to be pre-medicated before dental treatment?

YES NO If yes, explain: _____

Have you had any serious medical problems in the past?

YES NO If yes, explain: _____

Have you ever had allergies or adverse effects to dental anesthetic? YES NO

If yes, please explain: _____

Have you ever experienced difficulty becoming numb?

YES NO If yes, please explain: _____

Have you ever had any of the following diseases or medical problems?

- | | |
|-------------------------|--------------------------|
| Y N Angina | Y N Heart Attack |
| Y N Anemia | Y N Heart Murmur |
| Y N Anxiety Attacks | Y N Hepatitis |
| Y N Asthma | Y N Herpes |
| Y N Arthritis | Y N HIV/AIDS |
| Y N Artificial Joint | Y N Jaundice |
| Y N By-pass Surgery | Y N Kidney Disease |
| Y N Back Injury | Y N Other Prosthesis |
| Y N Blood Disease | Y N Pacemaker |
| Y N Chemical Dependency | Y N Prolapsed Valve |
| Y N Cancer Therapy | Y N Psychiatric Disorder |
| Y N Diabetes | Y N Radiation Treatments |
| Y N Eating Disorder | Y N Rheumatic Fever |
| Y N Epilepsy/Fainting | Y N Respiratory Problem |
| Y N Frequent Headaches | Y N Stroke |
| Y N Glaucoma | Y N Swollen Glands |
| Y N Hemophilia | Y N Sinus Problems |
| Y N High Blood Pressure | Y N Thyroid Disorder |
| Y N Low Blood Pressure | Y N Tuberculosis |
| | Y N Ulcers |

Are you allergic to any of the following?

Aspirin Codeine Latex

Metals Penicillin Sulfa

Other Allergies _____

DENTAL INFORMATION

When was your last dental visit? _____

Were X-Rays taken? YES NO

Frequency of dental visits? _____

Do you have any dental concerns today? YES NO

If yes, explain: _____

How do you feel about the appearance of your teeth?

Is there anything you would change about your smile?

Have you had any poor experiences with prior dentistry?

What did you **like most** about your prior dental office?

Are there any old fillings or dental work you do not like?

YES NO If yes, explain: _____

Are you concerned about bad breath? YES NO

Are you experiencing pain in your Jaw Joints?

YES NO If yes, explain: _____

Do you want to keep your natural teeth? YES NO

If there were a simple, inexpensive way to whiten your teeth, would you be interested? YES NO

Would you like your teeth to be whiter? YES NO

Has anyone discussed gum disease with you? YES NO

Please check the box if the description applies to you:

- | | |
|--|--|
| <input type="checkbox"/> Difficulty chewing on the right | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Difficulty chewing on the left | <input type="checkbox"/> Frequent cavities |
| <input type="checkbox"/> Painful facial joints | <input type="checkbox"/> Popping/Clicking |
| <input type="checkbox"/> Grinding/Clenching your teeth | <input type="checkbox"/> Difficulty flossing |
| <input type="checkbox"/> Headaches/Neck aches | <input type="checkbox"/> Ear Aches/Ringing |

UPDATES

Date: _____ Date: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Signature: _____ Signature: _____