

ABOUT YOU

Name: _____
Name MI Last

Preferred name: _____

Home Address: _____

City State Zip

Social Security #: _____

Date of Birth: _____ Age _____ Male Female
 Single Married Divorced Widowed

Name 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

Home # _____ Cell# _____

Work # _____ Alternate phone # _____

In the event of an emergency, is there someone we can contact? YES NO

Name: _____

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: _____

Date: _____

DENTAL BENEFITS

Do you have dental benefits? YES NO

Primary Insurance

Name of Subscriber: _____

Date of Birth: _____

Social Security or ID #: _____

Group #: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: _____

Employer's Name: _____

Employer's Phone #: _____

Employer's Address: _____

City State Zip

Secondary Insurance:

Name of Subscriber: _____

Date of Birth: _____

Social Security or ID #: _____

Group #: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: _____

Employer's Name: _____

Employer's Phone #: _____

Employer's Address: _____

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 between the insurance estimate and the actual insurance payment.

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: _____

CONTINUE TO BACK SIDE OF FORM



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: _____

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 problem?

- | | |
|--------------------------------|---------------------------------|
| Y N Anemia | Y N Heart Disease |
| Y N Angina | Y N Heart Murmur |
| Y N Anti Clott Med. | Y N Hemophilia |
| Y N Anxiety Attacks | Y N Hepatitis |
| Y N Arthritis | Y N Herpes |
| Y N Artificial Joints | Y N High Blood Pressure |
| Y N Asthma | Y N HIV/ AIDS |
| Y N Back Injury | Y N Jaundice |
| Y N Blood Disease | Y N Kidney Disease |
| Y N By Pass Surgery | Y N Liver Disease |
| Y N Cancer Therapy | Y N Low Blood Pressure |
| Y N Chemical Dependency | Y N Nervous Disorder |
| Y N Coronary Occlusion | Y N Pacemaker |
| Y N Diabetes | Y N Prolapsed Valve |
| Y N Dizziness | Y N Psychiatric Disorder |
| Y N Eating Disorder | Y N Radiation Treatment |
| Y N Epilepsy/Fainting | Y N Respiratory Problems |
| Y N Excessive Bleeding | Y N Sinus Problems |
| Y N Fainting | Y N Stomach Problems |
| Y N Frequent Headaches | Y N Stroke |
| Y N Glaucoma | Y N Swollen Glands |
| Y N Hay Fever | Y N Thyroid Disease |
| Y N Head Injuries | Y N Tuberculosis |
| Y N Heart Attack | Y N Ulcers |

Are you allergic to any of the following?

- | | | |
|--|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> 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: _____

OFFICE FINANCIAL POLICY

Welcome to our office. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We feel part of providing complete comprehensive dental services includes all treatment and financial information.

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at the time of services are rendered. For your convenience we accept cash, checks, Visa, Mastercard, Discover, and American Express.

Emergency Clients new to the practice, payment is due at the time services are rendered. Once you have established as existing, participating client then the office payment policies will apply.

Insurance benefits are determined by your employer and not your dentist. **Any deductible or estimated co-payment amount will be due at the time of treatment.** Insurance is not a guarantee of payment; they will not pay for all your costs. Your insurance policy is a contract between you and your insurance company. Your insurance and payment is still your responsibility. As a courtesy we will be glad to file your claim for you if you bring: 1) your dental insurance wallet card and 2) all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment. ***If payment for services already rendered has not been paid in full within 60 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible from you.***

We reserve the right to charge \$50.00 per half hour, and collect, for Broken Appointments – appointments that are cancelled or broken without 48-hours advance notice.

Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Returned Check Fee of \$25.00 will be added to your account balance and is collectible.

Separated / Divorced Parents of Minors who are each responsible for one half of the cost of a child's/children's dental care, the parent who brings the child in is responsible for paying the co-payment or full fee. It may be necessary to have a credit/debit number from the non-custodial parent on file.

Payment plans and financial arrangements are offered through Care-Credit our in-office financing partner.

I have read and understand this financial policy.

Print Name

Signature

Date