



**PATIENT INFORMATION**

Full Name: \_\_\_\_\_ How do you wish to be addressed? \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex (please circle): Male Female Social Security # \_\_\_\_\_

Marital Status: (please circle) Single Married Separated Divorced Widowed Minor

Mailing Address \_\_\_\_\_ Phone: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence (your actual street address) \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Are any of your family members patients here? \_\_\_\_\_ If so who? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

What church do you attend? (Optional) \_\_\_\_\_

**PERSON RESPONSIBLE FOR THIS ACCOUNT**

Who is responsible for this account? Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent/ Guardian \_\_\_\_\_ Other \_\_\_\_\_

(Please fill in the following information if the person responsible for account is different than self.)

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address (if different) \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: (work) \_\_\_\_\_ (home) \_\_\_\_\_

**INFORMATION ABOUT DEPENDENT PATIENTS**

Name of School \_\_\_\_\_

Special interest or hobbies \_\_\_\_\_

Does the water in your home contain fluoride? YES NO

Does your child take vitamins? YES NO Please list \_\_\_\_\_

Does your child suck thumb, fingers, or pacifier? YES NO

Father's Name: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

**Insurance / Financial Policies**

Today’s insurance does not take quality of care into consideration. A lack of insurance standards has promoted unpredictable and many times unexpectedly low benefits for you. Dental insurance today is nothing more than a partial payment for basic dentistry similar to getting a rebate check. It is, however, a benefit to some and we want to do what we can to maximize this benefit for you without it dictating the end result. It is important to note that you are responsible for understanding the coverage and its limitations that apply to your particular benefit plan.

As a practice we believe that the quality of care you receive is exceptional. We feel that lowering our standards to meet the guidelines of benefit plans is a disservice to our patients. Therefore, we will be asking all of our patients to pay for appointments in full and allow their benefit plan to reimburse them directly. As a courtesy to you, we will fill out all necessary claim forms for you and ask that you place them in your outgoing mail.

We are happy to offer to you the option of a payment plan with very attractive interest rates. This will allow you to charge your dental visit and in most cases you will receive your benefit reimbursement prior to any statements from any credit cards you may use. We will be happy to assist you with the application process. We have found that the benefit turnaround time is approximately 2-4 weeks. All you need to do is wait for the check.

**Broken or Failed Appointments**

We reserve the right to charge for any appointment that is broken or changed without at least 48 hours advance notice. Any deposit made will be considered your cancellation fee.

I understand that the responsibility for payment for all services provided in this office for myself, or my dependents, is mine due payable at the time of treatment. I also understand that if my account is still outstanding after 30 days from the date of service, my account may be referred to a collection agency or an attorney for collection. I agree to pay any interest on the total unpaid monthly balance at a rate of 24% APR. Such interest is to begin if the account is 30 days past due and is calculated from the date of service. I agree to pay all costs of collection, including but not limited to 35% collection fees and attorney fees of 33%, but not less than \$200, regardless if suit is filed and all court costs. All costs associated with any of these endeavors will also be assessed against me, including an administrative fee of \$50.00 for collection efforts assessed by this office. I hereby waive the benefit of my homestead exemption and all other exemptions. I authorize my employer to release all information regarding employment and salary verification. There will be a \$30.00 fee for all returned checks.

**Consent**

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to file insurance claims and documentation, to obtain payment, and for health care operations like quality reviews.

I have been informed that I may review the practice’s Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must then follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

I understand that the information I have given on this form is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status or contact information. I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with dental care of the patient listed on this form. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Guarantor**  
**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Do you have dental insurance? (please circle)                      YES                      NO

Dental Insurance Company \_\_\_\_\_ Whose name is the policy under? \_\_\_\_\_

Employer \_\_\_\_\_ Effective Date \_\_\_\_\_ Birth Date of Policy Holder \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

**DENTAL HISTORY**

Name of your former dentist \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

1. When was the last time you were there? \_\_\_\_\_

2. When were your teeth cleaned last? \_\_\_\_\_

3. Are any of your teeth sensitive to    Hot \_\_\_\_\_                      Cold \_\_\_\_\_                      Sweets \_\_\_\_\_                      Pressure \_\_\_\_\_

4. Do your gums bleed or hurt?                      YES                      NO

5. How do you feel about your teeth in general? \_\_\_\_\_

6. Do you have any discolored teeth that bother you?                      YES                      NO

7. Have you ever had any problems or complications with previous dental treatment?                      YES                      NO

Please explain \_\_\_\_\_

8. Does dental treatment make you nervous?                      YES                      NO

9. Do you experience pain in the jaw joint?                      YES                      NO

10. Do you have frequent headaches?                      YES                      NO                      How often? \_\_\_\_\_

11. Do you want full dental care?                      YES                      NO (just here for one specific problem)

12. Were you referred here by another dentist or physician?                      YES                      NO

Name of referring dentist or physician \_\_\_\_\_

## MEDICAL HISTORY

Name of your family physician \_\_\_\_\_ Date of last physical \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of specialist you are currently seeing \_\_\_\_\_ Phone \_\_\_\_\_

**Please answer yes or no to each of the following questions:**

1. Are you taking any medications? NO YES

List \_\_\_\_\_

2. Are you pregnant or suspect you may be? NO YES

3. Do you currently use birth control? NO YES

4. Do you eat/drink any grapefruit products on a regular basis? NO YES

5. Have you ever bled excessively after being cut or injured? NO YES

**Do you or have you ever had any of the following?**

*(Please circle that which applies)*

	Yes	No
<u>High Blood Pressure</u>	Y	N
<u>Low Blood Pressure</u>	Y	N
<u>Diabetes</u>	Y	N
<u>Arthritis</u>	Y	N
<u>Rheumatism</u>	Y	N
<u>Leukemia</u>	Y	N
<u>Anemia</u>	Y	N
<u>Tuberculosis</u>	Y	N
<u>AIDS or HIV Infection</u>	Y	N
<u>Stomach Problems</u>	Y	N
<u>Kidney Problems</u>	Y	N
<u>Liver Problems</u>	Y	N
<u>Asthma</u>	Y	N
<u>Psychiatric Treatment</u>	Y	N
<u>Epilepsy / Convulsions</u>	Y	N
<u>Seizure / Fainting</u>	Y	N
<u>Artificial joints / prosthesis</u>	Y	N

	Yes	No
<u>Have you ever had a major surgery</u>	Y	N
<u>Have you ever had a serious illness</u>	Y	N
<u>Heart Disease</u>	Y	N
<u>Cardiac Pacemaker</u>	Y	N
<u>Artificial Heart Valve</u>	Y	N
<u>Rheumatic Fever</u>	Y	N
<u>Heart Murmurs</u>	Y	N
<u>Mitral Valve Prolapse</u>	Y	N
<u>Hepatitis</u>	Y	N
<u>Sexually Transmitted---</u>		
<u>----Disease</u>	Y	N
<u>Consume Alcoholic Beverages</u>	Y	N
_____	Y	N
<u>Habitually Use Controlled Substances</u>	Y	N
_____	Y	N
<u>Smoke(d), chew(ed) snuff, or any other forms of Tobacco</u>	Y	N

**Are you allergic to or have you had reactions to:**

	Yes	No
<u>Local Anesthetic like Novocaine</u>	Y	N
<u>Penicillin or other Antibiotics</u>	Y	N
<u>Sulfa Drugs</u>	Y	N
<u>Sedative or Sleeping Pills</u>	Y	N
<u>Aspirin</u>	Y	N
<u>Iodine</u>	Y	N
<u>Any Metals (Nickel, Mercury, etc)</u>	Y	N
<u>Latex / Rubber</u>	Y	N
<u>Other (Please List)</u>		
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If you answered yes to any of the questions please explain:

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