Patient Information

Please Print **Date**: ____________________

Patient Name: ________________ First ___ MI ________________ Last ________________ Preferred Name

Address: ____ ______________ City ___ State ________ Zip Code

Phone: ______________ Home ______________ Work ______________ Cell SSN: ________________

Birth Date: ______________ Gender (Circle): **M** **F** Employer: ______________________________

Email: ______________________________ Family Status: ☐Child ☐Single ☐Married ☐Other

If Married: ________________ Spouse's Name ________________ Spouse's Date of Birth If Child: ______________________ Parent / Guardian Name

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Internet ☐ Phonebook ☐ Insurance ☐ Other ____________________

Dental Insurance Information

Do you have Dental Insurance? (circle) Yes No ***WE DO NOT FILE SECONDARY INSURANCE***

Subscriber Name	
Subscriber SSN	
Subscriber Date of Birth	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name	
Employer Phone Number	
Insurance Company Name	
Insurance ID Number	
Insurance Group Number	
Insurance Phone Number	

Please present insurance card to the receptionist to be photocopied

I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO BE PAID DIRECTLY TO THE PROVIDER; IF I DO NOT HAVE INSURANCE I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.

Signature on File: ________________________________ **Date:** ______________

Information on this form is kept confidential

Medical History

If Yes, Please List:

Are you under a physician's care now? ___Yes ___No ______________________________
Have you ever been hospitalized or had a major operation? ___Yes ___No ______________________________
Are you taking any medication, pills or drugs? ___Yes ___ No ______________________________
Do you use controlled substances? ___Yes ___No ______________________________
Do you use tobacco? ___Yes ___No ______________________________

Women are you: Pregnant___ / Trying to get pregnant ___ / Nursing ____ / Taking Contraceptives___

Are you Allergic to any of the following:
Aspirin ___ Penicillin ___ Codeine___ Acrylic ___ Metal __ Latex __ Local Anesthetics___
Amoxicillin ___ Sulfa ___ Other (Please List):____

Do you have or ever had any of the following:

___AIDS/HIV Positive
___Alzheimer's Disease
___Anemia
___Arthritis/Gout
___Artificial Heart Valve*
___Artificial Joints*
___Asthma
___Blood Disease
___Blood Transfusion
___Cancer
___Chemotherapy
___Cold Sores/Fever Blister
___Congenital Heart Disorder
___Diabetes
___Emphysema
___Epilepsy/Seizures
___Excessive bleeding
___Fainting/Dizziness
___Frequent Headaches
___Herpes Simplex
___Glaucoma
___Hay Fever/Allergies
___Heart Attack/Failure
___Heart Disease
___Heart Murmur*
___Hemophilia
___Hepatitis A, B, or C
___High Blood Pressure
___Hives or Rash
___Hypoglycemia
___Kidney Disease
___ Leukemia
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___Mitral Valve Prolapse*
___ Renal Dialysis
___ Rheumatic Fever*
___ Scarlet Fever
___ Shingles
___ Sickle Cell Disease
___ Sinus Problems
___Spina Bifida
___Stroke
___Swelling
___Thyroid Disease
___Tonsillitis
___Tuberculosis
___Tumors
___Ulcers

Have you ever had any serious illness not listed? _____ Yes _____ No
Comments:

Patient Dental History:

Do your gums bleed while brushing or flossing? __Yes __No
Are your teeth sensitive to hot/cold liquid or food? __Yes __No
Do you feel pain in any of your teeth? __Yes __No
Have you had any head, neck, or jaw injuries? __Yes __No
Do you like your smile? __Yes __No
Would you like your teeth to look whiter? __Yes __No
Do you clench or grind your teeth? __Yes __No
Prolonged bleeding after extractions? __Yes __No
Have you had any orthodontic treatment? __Yes __No
Do you wear dentures or partials? __Yes __No
Do you have frequent headaches? __ Yes __No
Do you have clicking or pain in your jaw?__ Yes __ No

How long has it been since your last dental visit? ______________________________________

Authorization and Consent:
I certify that I have read and understand the above information to the best of my knowledge and have accurately answered. I understand that providing the incorrect information can be dangerous to my health. I give my consent to be seen by the doctor and if I elect treatment, I consent for the work to be done and understand that during the course of the procedure(s) unforeseen conditions may occur which necessitate procedures other than contemplated. I am aware there may be additional charges.
If a collection problem arises, I understand that I am responsible for all collection fees including attorney fees, court costs, and late charges. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
Appointments:
When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice.
HIPAA:
I have received and acknowledged the Notice of Privacy Practice and consent for use and disclosure of health information. I give this practice consent to use or disclose my health information to carry out treatment, obtain insurance payments and health care operations.

Patient or Guardian Signature: ____________________________ Date: ____________

Office Financial Policy

We are very conscious of the investment in your oral health and believe that we provide the best dental care possible. We request our patients to pay for their treatment at the time it's completed unless other arrangements have been made. All recommended treatment will be reviewed and discussed with you after your initial examination.

A written treatment plan will be provided and options will be discussed with you. We live by the golden rule of "treat others as you would like to be treated," so only the optimal treatment will be prescribed.

We have financial options available to make the treatment work for you. If needed, a financial contract will be presented and created with you to fit your needs.

For your convenience, we accept: cash, Visa, Master Card, Discover, American Express and personal checks. Care Credit and Citi Financial are also an accepted payment method.

Insurance benefits are determined by your employer and not your dentist. Insurance doesn't guarantee payment. Any deductible or estimated co-payment amounts will be due at the time of treatment. We only provide estimates using your dental insurance, any amount not covered by your insurance will be 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 the office is unable to verify your insurance information before treatment.

We reserve the right to charge and collect fees for broken appointments – appointments that are cancelled or broken without 24-hours advance notice. Appointments are reserved exclusively for you.

I have read and understand this financial policy.

Signature: ____________________________________ Date: ______________________

Printed Name: ________________________________