Welcome!

To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please ask someone at the front desk and we will be happy to help you. Thanks for being our patient!

Patient Information

Name _____
Last First MI

Preferred Name _____ Title _____

☐Male ☐Female ☐Child ☐ Single ☐ Married ☐ Other

Date of Birth _____ SSN _____

Driver's Lic. _____ State _____
(photocopy required)

Address _____

_____
City State Zip Code

Home Phone _____ Alternate Phone _____

Email _____

Employer _____ Wk Phone _____

Emergency Contact Name/Phone _____

How did you hear about us? _____

Insurance Information

Insured Employee _____

Insured's SSN _____ DOB _____

Insurance Company _____ Phone _____

Employer _____ Group # _____

Insured's Relationship to Patient _____

College (full-time students only) _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____
Responsible Party Signature

_____ _____
Relationship to Patient Date

Office & Financial Policies

At least 48 hours is required for appointment changes or cancellations. Appointments cancelled with less than 48 hours notice incur a $50 charge; an additional $50 fee is charged for appointments with specialists.

Valid identification is required for all personal checks. Returned checks will be subject to the terms and conditions of the electronic check acceptance company used in this office, including any fees charged by that company.

Payment and/or Co-payment is required in full at the time services are rendered. In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that Medical/Dental Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned understands that the co-payment requested for services is only an ESTIMATE of what the insurance will not cover based upon information provided by the insurance company and NOT A GUARANTEE OF PAYMENT. The actual insurance benefit may differ from our estimates**. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY UNPAID BALANCE**.

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I : { } **am** { } **am not** an active duty member of the U. S. Armed Forces.

I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.

_____ _____
Responsible Party Signature Date

Over Please...

Dental Health History

Name:_____

Reason for today's visit _____

_____

Former Dentist _____

Phone _____

Date of last dental exam _____

Date of last dental x-rays _____

Date of last cleaning _____

How often do you brush?_____

How often do you floss?_____

Do you feel pain anywhere?_____

Describe _____

_____

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Sensitivity to hot or cold	Yes	No	Blisters on lips or mouth	Yes	No
Sensitivity to sweet	Yes	No	Sores or growths inside cheek / in the mouth	Yes	No
Avoid one side of the mouth when chewing	Yes	No	Bad breath	Yes	No
Sensitivity when biting	Yes	No	Burning sensation on tongue	Yes	No
Broken / cracked fillings	Yes	No	Dry mouth	Yes	No
Food collection between teeth	Yes	No	Accident involving jaw	Yes	No
Tobacco use	Yes	No	Clicking or popping jaw	Yes	No
Gums swollen or tender	Yes	No	Frequent headaches	Yes	No
Gums bleed frequently	Yes	No	Grinding teeth	Yes	No
			Jaw pain or tiredness	Yes	No
			Pain around ear	Yes	No
			Orthodontic treatment	Yes	No
			Periodontal treatment	Yes	No

Medical Health History

Physician _____ Phone _____

Please list all current medications (include prescription, over-the-counter, herbal supplements) and reason for use:

_____

_____

_____

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Valium

Other: _____

Have you ever had any of the following conditions?

☐ Artificial joint/valve ☐ Heart murmur ☐ Mitral valve prolapse ☐ Rheumatic fever

Women Only:

Do you use birth control medication?	Yes	No
Are you nursing?	Yes	No
Are you pregnant? (Due date:_____)	Yes	No

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

AIDS / HIV	Yes	No
Anemia	Yes	No
Arthritis or Back problems	Yes	No
Asthma or Respiratory problems	Yes	No
Blood transfusion (Date:_____)	Yes	No
Cancer	Yes	No
Cardiac pacemaker	Yes	No
Convulsions / Epilepsy / Seizures	Yes	No
Diabetes	Yes	No
Excessive bleeding with surgery / extractions	Yes	No
Heart problems	Yes	No
Hepatitis or Liver problems	Yes	No
High or Low blood pressure	Yes	No
Kidney problems	Yes	No
Phen-Phen treatment	Yes	No
Radiation or Chemotherapy treatment	Yes	No
Stroke	Yes	No
Thyroid disorder	Yes	No
Tuberculosis	Yes	No
Other:	Yes	No

_____

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

_____ _____

X Responsible Party Signature Date

_____ _____

X Attending Dentist Signature Date