Patient Information

PATIENT

Name_____

Address _____

City _____State_____ Zip_____

Phone ( ) _____

Cell ( ) _____

Do you allow us to send reminder texts? ☐Yes ☐No

E-mail_____

Social Security # _____

DL#_____

Age_____ Birthdate_____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____

Address _____

City _____ State _____Zip_____

Phone ( ) _____

Social Security # _____

DL#_____

Relationship to Patient _____

Age _____ Birthdate _____

INSURANCE / DENTAL PLAN

Primary Insurance: _____

Plan ID # _____

Plan Name _____

Address_____

City _____State_____ Zip_____

Insurance / Plan Phone #_____

Employer_____

Union/Local, Group # Plan#_____

Insured's Name_____

Insured's Soc. Sec. #_____ DOB_____

INSURANCE / DENTAL PLAN

Secondary Insurance: _____

Plan Name _____

Address_____

City _____State_____ Zip_____

Insurance / Plan Phone #_____

Employer _____

Union/Local, Group # Plan# _____

Insured's Name_____

Insured's Soc. Sec. # _____ DOB_____

PERSON TO CONTACT FOR EMERGENCY:

Name _____

Phone ( ) _____ Relation _____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.

2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.

3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.

4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

_____ _____

Signature of Responsible Party or Patient
(Parent if Patient is a Minor)

Date

GENERAL HEALTH INFORMATION

DATE: _____ CHART #_____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

DENTAL HISTORY

1. **Reason for Visit / Main Concern**? Check-Up ☐ Cleaning ☐ Toothache ☐ Other _____
2. Are there other conditions of which we should be aware? YES ◯ NO ◯ If yes, please specify: _____
3. When did you last visit a dentist? _____ 4. What treatment was performed? _____
5. Was the treatment completed? _____ 6. When were dental x-rays taken? _____
7. Did you have a cleaning ? YES ◯ NO ◯ 8. Have you had gum (periodontal) treatment? YES ◯ NO ◯
9. Have you ever had prolonged bleeding after an extraction? YES ◯ NO ◯ If yes, please specify: _____
10. Have you had any problems with past dental treatment? YES ◯ NO ◯ If yes, please specify: _____
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES ◯ NO ◯ If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES ◯ NO ◯ If yes, please specify: _____
13. Do your gums bleed easily? YES ◯ NO ◯ 14. Do you feel you have bad breath? YES ◯ NO ◯
15. Are your teeth sensitive to hot or cold? YES ◯ NO ◯ 16. Would you like your teeth whiter? YES ◯ NO ◯
17. Are you happy with your smile? YES ◯ NO ◯ If no, please explain: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES ◯ NO ◯ If yes, please specify: _____ Dr. Name: _____
   Dr. Phone: ( ) _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES ◯ NO ◯ If yes, please specify: _____
4. (Women) Are you pregnant now? YES ◯ NO ◯ If yes, how many months? _____ Are you nursing? YES ◯ NO ◯
5. Are there any other health problems of which we should be advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"			Doctor Comments	Please check "YES" or "NO"			Doctor Comments
ARTIFICIAL HEART VALVE	YES ◯	NO ◯		HEPATITIS	YES ◯	NO ◯	
AIDS/HIV+	YES ◯	NO ◯		HIGH BL. PRESSURE	YES ◯	NO ◯	
ANEMIA	YES ◯	NO ◯		JAUNDICE	YES ◯	NO ◯	
ANGINA	YES ◯	NO ◯		JOINT REPLACEMENT	YES ◯	NO ◯	
ARTHRITIS	YES ◯	NO ◯		KIDNEY DISEASE	YES ◯	NO ◯	
ASTHMA	YES ◯	NO ◯		LATEX ALLERGY	YES ◯	NO ◯	
BISPHOSPHONATE THERAPY	YES ◯	NO ◯		LIVER PROBLEMS	YES ◯	NO ◯	
BLEEDING PROBLEMS	YES ◯	NO ◯		LOW BL. PRESSURE	YES ◯	NO ◯	
CANCER	YES ◯	NO ◯		LUNG DISEASE	YES ◯	NO ◯	
CHEMO/RAD THERAPY	YES ◯	NO ◯		PACEMAKER	YES ◯	NO ◯	
COSMETIC SURGERY	YES ◯	NO ◯		PSYCHIATRIC CARE	YES ◯	NO ◯	
DIABETES	YES ◯	NO ◯		RHEUMATIC FEVER	YES ◯	NO ◯	
DIZZY SPELLS	YES ◯	NO ◯		SINUS TROUBLE	YES ◯	NO ◯	
DRUG ADDICTION	YES ◯	NO ◯		SLEEP APNEA	YES ◯	NO ◯	
EMPHYSEMA	YES ◯	NO ◯		TOBACCO	YES ◯	NO ◯	
EPILEPSY	YES ◯	NO ◯		STROKE	YES ◯	NO ◯	
FAINTING	YES ◯	NO ◯		THYROID PROBLEMS	YES ◯	NO ◯	
GLAUCOMA	YES ◯	NO ◯		TMD OR TMJ	YES ◯	NO ◯	
HEART ATTACK/SURGERY	YES ◯	NO ◯		TUBERCULOSIS	YES ◯	NO ◯	
HEART MURMUR/PROBLEMS	YES ◯	NO ◯		VENEREAL DISEASE	YES ◯	NO ◯	

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____
(Parent if Patient is a Minor)

Doctor Signature _____

MEDICAL UPDATE:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____

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Payments

We Accept payments in the forms of cash, personal/company checks, money orders, MasterCard, Visa, Discover, and American Express.

Initials_____

Insurance

If you have insurance, we will be happy to file your claim as a courtesy. However you will be responsible for your deductible and any coinsurance at the time of service. Our Computer software estimates what your insurance should cover and estimates what your "out of pocket" portion should be. THIS IS ONLY AN ESTIMATE and it possible that your insurance may cover less than what is estimated. If this should happen then the remaining balance will be your responsibility to pay in a timely manner.

Initials_____

Delinquent Accounts

We will consider an account delinquent when the balance goes unpaid in 60 days without financial arrangement in place or on accounts with financial arrangements that have defaulted on the agreed upon financial arrangement. Patient who have had their accounts delinquent will no longer be considered active in the dental practice and will only be seen on a cash basis once the balance has been taken care of.

Initials_____

Medical Records Releases

We will only share your medical/personal information when pertinent with other Dental or Medical Professionals with whom we are referring care to if needed. This Information will also be used only as needed when submitting insurance claims on your behalf. We will only release x-rays and records once release form has been signed by the patient.

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Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. Our policy is as follows: We require that you give our office **48 hours' notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$40** will be charged for regular appointment and **$80** for longer appointments. No future appointments can be scheduled nor can records be transferred without the payment of this fee. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms.

I, _____ (print name), have received a copy of the Appointment Cancellation Policy.

_____ _____

Signature of Patient Date