



Welcome to our office!

To serve you the best, please provide the following information – all information is confidential.

Patient Information

Patient Name: Last, First MI (Preferred Name) Date:

Social Security #: Driver's License #: Birth Date:

Phone (Home): (Work): (Mobile) Phone:

Email Address:

Address: Street Apartment # City State Zip Code

- Male
Female
Single
Married
Child

Employer Name: Occupation:

Employer Address: Street City, State Zip Code

Dental History

What is the reason for your visit today?

How do you feel about visiting the Dentist?

Date of last dental exam: Date of last dental cleaning:

Have you ever had any complications with dental treatment? Yes No

If yes, please explain:

To be completely comfortable, would you prefer to be sedated during dental treatment? Yes No

If you could change your smile, what would you change?

- Straight teeth Whiter teeth Close gaps between teeth Replace missing teeth Worn teeth
More youthful smile Replace metal fillings with tooth colored fillings Restore broken teeth

Do you have any of these concerns:

- Bad breath Cold Sores Bleeding Gums Morning headaches Jaw joint pain
Teeth grinding / clenching Athletic Sports guard Receding Gumline Dry Mouth

Referral Information

Whom may we thank for referring you to our practice?

- Another patient, friend Another patient, relative Insurance Provider List Yellow Pages
Postcard School Work Other

Name of person or office referring you to our practice:

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last, First MI

**Responsible Party Information**  
*(if different from patient)*

Name: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Relationship to the patient: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street Apartment #  
 \_\_\_\_\_  
City State Zip Code

**Insurance Information**

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI  
 Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Insured's Address: \_\_\_\_\_  
Street City State Zip Code  
 Insured's Employer Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street City State Zip Code  
 Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
 Insurance Plan Name and Address: \_\_\_\_\_

**Health Information**

Have your ever had any of the following? Please circle individually Yes/No:

- |                                      |                                     |                            |                         |
|--------------------------------------|-------------------------------------|----------------------------|-------------------------|
| Y / N Allergies/Seasonal             | Y / N Cancer                        | Y / N High Blood Pressure  | Y / N Shingles          |
| Y / N Allergy - <b>Aspirin</b>       | Y / N Chemotherapy                  | Y / N HIV                  | Y / N Sinus Problems    |
| Y / N Allergy - <b>Codiene</b>       | Y / N Congenital Heart Lesion       | Y / N Jaundice             | Y / N Sjogrens Syndrome |
| Y / N Allergy - <b>Erythromycin</b>  | Y / N Diabetes                      | Y / N Kidney Disease       | Y / N Stomach Problems  |
| Y / N Allergy - <b>LATEX</b>         | Y / N Dizziness/Head Injuries       | Y / N Liver Disease        | Y / N Stroke            |
| Y / N Allergy - <b>Metal/Jewelry</b> | Y / N Drug Abuse/Addiction          | Y / N Mental Disorders     | Y / N Thyroid Disease   |
| Y / N Allergy - <b>PENICILLIN</b>    | Y / N Epilepsy                      | Y / N Nervous Disorders    | Y / N Tuberculosis      |
| Y / N Allergy - <b>SULFA</b>         | Y / N Fainting                      | Y / N Pacemaker            | Y / N Tumors            |
| Y / N Anemia                         | Y / N Glaucoma                      | Y / N Pain in Jaw Joints   | Y / N Ulcers            |
| Y / N Angina Pectoris                | Y / N Heart Attack/Surgery/Disease  | Y / N Pregnancy            | Y / N Uses Tobacco      |
| Y / N Arthritis/ Rheumatism          | Y / N Heart Murmur/M V P            | <b>Due Date:</b> _____     | Y / N Venereal Disease  |
| Y / N Artificial Heart Valve         | Y / N Heart Pacemaker               | Y / N Radiation Treatment  | Other: _____            |
| Y / N Artificial Joints              | Y / N Hemophilia/Excessive Bleeding | Y / N Respiratory Problems |                         |
| Y / N Asthma                         | Y / N Hepatitis                     | Y / N Rheumatic Fever      |                         |
| Y / N Blood Disease                  | Y / N Herpes                        | Y / N Scarlet Fever        |                         |

• Do you have any health problems or conditions or diseases that are not listed above?  Yes  No

If yes, please explain: \_\_\_\_\_

• Name of Pharmacy/Location: \_\_\_\_\_ Phone: \_\_\_\_\_

• Please list all medications you are currently taking including all over the counter products: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor before treatment.

Signature of patient, parent or guardian

Date

Signature of the Doctor

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last, First MI



## Office Policies

### Financial Policy Agreement

- Payment is expected at the time when services are provided. If you have insurance, the estimated patient portion of the fee is due at the time of service. Any other payment arrangement must be made in advance of services.
- We allow extra time for the insurance company to pay their estimated portion.
- If the insurance company has not fully paid a claim after a reasonable period of time, (usually 30 days) you will be required to pay that remaining portion.
- As a courtesy, we are happy to verify your benefits and bill your insurance. Information received is not a guarantee of benefits or payment from the insurance company, we use this information to estimate as closely as possible your insurance coverage.
- I understand that any costs incurred during treatment are my responsibility. I realize that insurance may help pay part of my treatment and that the estimates quoted to me are only *estimates*. I will be responsible for any fees unpaid by the insurance company. I understand that there may be monthly interest (1.5%) applied to the balance, and any additional costs of collection will be applied to the balance.

### Cancellation Policy Agreement

- I understand that if I fail to give **48 hours notice** to cancel a scheduled appointment, that I may be charged a fee up to the amount of the scheduled appointment procedure.

### Notice of Privacy Practices Acknowledgement

- Under the *Health Insurance Portability & Accountability Act of 1996* (HIPAA) I have certain rights to privacy regarding my protected health information. This information is used to conduct to your treatment, obtain payment from third party payers, and other various uses. I acknowledge that I have received your *Notice of Privacy Practices* containing a complete description of the uses of my health information and how I may restrict the use of this information.

### Consent for Treatment

- I give consent for dental treatment by the doctor and staff.
- I understand that with each procedure there are particular risks and benefits. Possible risks for even routine treatment (such as fillings, crowns, root canals, and extractions) can be sensitive teeth, infection, paresthesia, traumatized pulp (nerve). Additional procedures may be required to treat any further complication.
- The practice of dentistry is not an exact science, and although we strive to give best care possible, guarantees can not be made concerning the results of the treatment.
- I consent to the use of local anesthetics, antibiotics, nitrous oxide (laughing gas), and analgesics (pain medications) as needed to complete treatment.
- I understand that I may ask questions at any time regarding the risks and benefits and alternatives for any recommended treatment.

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of guarantor of payment/responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient