



PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE CHILD MALE FEMALE
 SOCIAL SECURITY / PATIENT ID _____ BIRTHDATE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 PHONES: HOME _____ WORK _____ CELL _____
 EMAIL _____ PREFERRED METHOD OF CONTACT _____
 PATIENT EMPLOYER _____ F/T STUDENT? _____ SCHOOL _____
 EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOW DID YOU HEAR ABOUT US? _____
 EMERGENCY CONTACT _____ PHONE _____ RELATION _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATION _____
 ADDRESS (If different from above) _____
 PHONES: HOME _____ WORK _____ CELL _____
 NAME AND ADDRESS OF EMPLOYER _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
 BIRTHDATE _____ SOCIAL SECURITY / INSURED ID _____
 EMPLOYER _____ ADDRESS _____
 WORK PHONE _____
 INSURANCE COMPANY _____ GROUP # _____
 INSURANCE CO ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOW MUCH IS YOUR DEDUCTIBLE? _____ ANNUAL MAXIMUM _____ REMAINING AMOUNT _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
 BIRTHDATE _____ SOCIAL SECURITY / INSURED ID _____
 EMPLOYER _____ ADDRESS _____
 WORK PHONE _____
 INSURANCE COMPANY _____ GROUP # _____
 INSURANCE CO ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOW MUCH IS YOUR DEDUCTIBLE? _____ ANNUAL MAXIMUM _____ REMAINING AMOUNT _____

METHOD OF PAYMENT

- PAYMENT IN FULL AT TIME OF VISIT
- I WISH TO DISCUSS THE OPTIONS FOR THIRD PARTY FINANCING OF DENTAL CARE

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

DENTAL HISTORY

What is the nature of today's visit? Exam Consultation Emergency _____

Previous dentist _____ Phone _____ City _____

Date of last dental care _____ Last X-rays _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

- Bad breath
- Grinding or clenching
- Sensitivity to sweets
- Bleeding gums
- Loose or broken fillings
- Sensitivity when biting
- Clicking or popping of the jaw
- Periodontal treatment
- Sores or growths in the mouth
- Trapping food between teeth
- Sensitivity to cold
- Sensitivity to hot

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? If so, what? _____

Other information about your dental health or treatment? _____

MEDICAL HISTORY

Physician's Name _____ City _____ Phone _____

Date of last visit _____ Have you had any serious illness or operations? Yes No

If yes, please describe _____

Are you currently under physician care? Yes No If yes, please describe _____

Have you ever had a blood transfusion? Yes No If yes, please give approximate date _____

Have you ever taken Fen-Phen / Redux? Yes No Have you ever taken osteoporosis medications? Yes No

Women: Are you pregnant? Yes No Are you nursing? Yes No Are you using birth control medication? Yes No

Check if you have had any of the following:

- AIDS / HIV positive
- Anaphylaxis
- Anemia
- Arthritis, rheumatism
- Artificial heart valve
- Artificial joints
- Asthma
- Atopic (allergy prone)
- Back problems
- Blood disease
- Cancer
- Chemical dependency
- Chemotherapy
- Circulatory problems
- Cortisone treatments
- Cough, persistent
- Cough up blood
- Diabetes
- Epilepsy
- Fainting
- Food allergies
- Glaucoma
- Headaches
- Heart murmur
- Heart problems
- Describe _____
- Hemophilia/abnormal bleeding
- Herpes
- Hepatitis
- High blood pressure
- Jaw pain
- Kidney problem
- Liver disease
- Material allergies (latex, wool, metal, chemicals)
- Mitral valve prolapse
- Nervous problems
- Pacemaker / heart surgery
- Psychiatric care
- Rapid weight gain / loss
- Radiation treatment
- Respiratory disease
- Rheumatic/scarlet fever
- Shingles
- Shortness of breath
- Skin rash
- Spina Bifida
- Surgical implant
- Swelling of feet or ankles
- Thyroid disease/malfunction
- Tobacco habit
- Tonsillitis
- Tuberculosis
- Ulcer / Colitis
- Venereal disease

Is patient currently taking any medications? If yes, please list all: _____

Does patient have any drug allergies? If yes, please list all: _____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in health. I authorize the use of this signature as "signature on file" for all benefit submissions. I authorize the dentist to release any information necessary to secure payment of benefits. I understand that I am financially responsible for all charges rendered, regardless of and benefit plan. I consent to the use and disclosure of my protected health information to carry out healthcare operations, treatment and payment activities (HIPAA).

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relation to Patient

I have received copies of the Dental Material Facts Sheet and HIPAA Privacy Practices _____

Oral Health Risk Factors

Patient's Name: _____

1. Do you smoke or have you **EVER** smoked? Yes No
(If No, proceed to question 2)

The amount that you are presently smoking (Check ALL that apply)

- ___None (quit smoking completely) ___Less than 1 pack of cigarettes per day ___An occasional cigar
___An occasional cigarette ___1-2 Packs of cigarettes per day ___Cigars on a daily / regular basis
___A few cigarettes per Day ___2 or more packs of cigarettes per day ___Occasional pipe smoker
___A pipe on a daily / regular Basis

If you have quit smoking, when did you quit?

- ___Less than 6 months ago ___6 months to a year ago ___1 to 3 years ago ___Over 3 years ago

How many years have you or did you smoke?

- ___Less than 2 years ___2-5 years ___5-10 years ___10-20 years ___Over 20 years

2. Do you / Have you **EVER** chew/chewed tobacco or use/used snuff or other similar substance? Yes No
(If No, proceed to question 3)

Are you **STILL** using smokeless tobacco or snuff? Yes No

If No, **WHEN** did you quit?

- ___Less than 6 months ago ___6 months to a year ago ___1 to 3 years Ago ___Over 3 years ago

How many years did you use or have you used smokeless tobacco?

- ___Less than 1 year ___1-2 years ___2-5 years ___Over 5 years

3. Approximate average amount of alcoholic beverages presently consumed per week:

- ___None ___Less than 1 per week ___1-5 drinks ___6-11 drinks ___11-20 drinks ___Over 20 drinks

4. Do you have or have you ever had a substance abuse problem? Yes No

Describe _____

5. Do you presently use any recreational drugs? Yes No

List _____

6. Do you have or have you ever had an eating disorder? Yes No

If Yes, Please Specify: _____

7. Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears) Yes No

List _____

8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)? Yes No

9. Please list your history or any family member's history of cancer:

10. Other concerns and considerations:

CONSENT—To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care

Signature _____ Date _____

(Parent or guardian, if patient is a minor)



Dell A. Goodrick, DDS, FAGD

FINANCIAL INFORMATION

We are committed to providing you with the best possible dental care.

Payment for services is due at the time services are rendered, unless prior payment arrangements have been made and approved in writing. We gladly accept Visa, MasterCard, Discover, American Express, checks or cash. For larger amounts, we also offer financing through Care Credit, Capital One Healthcare Finance, Springstone, and Chase Health Advance.

A charge may be made for an appointment failed or cancelled without 48 business hours notice, at the rate of half the scheduled treatment fee. Appointment time is reserved in advance and with short or no notice, we do not have the opportunity to fill the time with another guest. We value your time and also ask that you please consider our efforts to accommodate those guests needing or waiting to come in.

Returned checks are subject to additional collection fees and interest charges of 1.5% per month. If an account becomes delinquent, the guarantor will be responsible for all legal fees incurred in collection of that account.

Your benefit plan is a contract between you, your employer and the insurance company and we are not a party to that contract. We are your advocate to help you receive the maximum benefit provided by your benefit plan, and are happy to assist you in understanding your specific plan. It is very difficult to estimate benefits and not all services are covered in all contracts. All policies have limitations and restrictions in order to keep the premium lower to the employer or sponsor. For example, some plans will reduce benefits to the “lowest standard of care,” such as giving allowance for a “silver” filling rather than tooth-colored fillings. This does not dictate what treatment you are entitled to, should be done, or change the treatment plan suggested for you; rather it is the limitation of the benefit paid for that type of procedure.

If you have any questions about the above information, please do not hesitate to ask. We are here to help you.

- ◆ I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for payment of my account, regardless of my insurance.
- ◆ I give permission for Dr. Dell Goodrick and his team to take and necessary diagnostic films, photos or study models to properly enable complete diagnosis and treatment.
- ◆ I have read the above statements. I fully understand and agree to these terms and conditions.

Signature of Responsible Party

Date

Dell A. Goodrick, DDS, FAGD

With recent advancements in materials and techniques, many of our patients are inquiring about cosmetic dental procedures. In order to better serve you, please take a moment to let us know how you feel about the appearance of your smile.

Name: _____ Date: _____

	YES	NO
Do you like the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth as straight as you would like them to be?	<input type="checkbox"/>	<input type="checkbox"/>
Are you happy with the length, width, and shape of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have a “gummy” smile?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any chipped teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any missing teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any spaces between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any discoloration, stains, or spots on your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your teeth to be whiter?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any dental work that you do not like?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any silver fillings that you would like changed to white?	<input type="checkbox"/>	<input type="checkbox"/>
Do you know anyone that has any cosmetic dentistry that interests you?	<input type="checkbox"/>	<input type="checkbox"/>

From the above questions, which concerns you the most?

If you could change anything about the appearance of your teeth, what would it be?
