

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

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: _____

Secondary

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: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

DENTAL CONCERNS

WHAT CAN WE DO TO MAKE YOU FEEL MORE AT HOME?

- ? Would you like to be reminded of your appointments?
? By Phone ? By e-mail ? By both
- ? Would you like fresh coffee when you arrive?
- ? Would you like a personal walkman or CD player to listen to?
- ? Will you need blankets to help with the temperature?
- ? Will you need a pillow to support your neck?
- ? Would you like sunglasses to wear during your appointment?
- ? Can you suggest any other amenities which would make your dental appointment more comfortable? _____

WHAT DID YOU NOT LIKE ABOUT PREVIOUS DENTAL APPOINTMENTS?

- ? Was the treatment itself uncomfortable? Please explain: _____
- ? Was the staff unfriendly? Please explain: _____
- ? Were there financial issues that were not properly explained?

WHAT ARE YOUR FEELINGS ABOUT THE FOLLOWING:

Front Teeth

- Are you happy with the color? ? Yes ? No
- Are you happy with the length? ? Yes ? No
- Are they crowded or crooked? ? Yes ? No Are braces an option for you? ? Yes ? No
- Are you happy with their overall appearance? ? Yes ? No
- Can you tell us what, if anything, you would like to change about them? _____

Back Teeth

- Are they sensitive to hot or cold foods/drinks? ? Yes ? No
- Does food get trapped between them when you eat? ? Yes ? No
- Is there anything about them you would like to change? _____

Gums

- Do they ever bleed? ? Yes ? No Are they sensitive? ? Yes ? No
- Are you seeing a Periodontist? ? Yes ? No If yes, who? _____
- Do you think you have bad breath? ? Yes ? No
- Is there anything about them you would like to change? _____

Missing Teeth

- Do you have any missing teeth? ? Yes ? No
- Are you wearing a replacement? (denture/partial/crown/bridge) ? Yes ? No
- Is your denture or partial comfortable? ? Yes ? No
- Have you ever been told about implants and how they can work for you? ? Yes ? No

WHAT IS THE VERY FIRST THING YOU WOULD LIKE US TO DO TO HELP YOU?

RECORDS RELEASE FORM

To Dr. _____

I hereby authorize release of Dental records for _____
to be sent to: [please print name]

John F. Midlige, D.M.D.
60 Midvale Road
Mountain Lakes, N.J. 07046

Signature: _____
Date: _____