



**ABOUT YOU**

All information required.

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

I prefer to be called \_\_\_\_\_ M \_\_\_ F \_\_\_

Birthdate \_\_\_ / \_\_\_ / \_\_\_ SS# \_\_\_\_\_

Driver's License # \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Single    Married    Divorced    Widowed

**Circle yes or no please:**

Facebook: Yes / No   Twitter: Yes / No

MySpace: Yes / No   Text Messaging: Yes / No

Home # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Other # (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation \_\_\_\_\_

Last Dental Visit \_\_\_\_\_

How did you hear about our office?

\_\_\_\_\_

**INSURANCE COVERAGE**

**Primary**

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_) \_\_\_\_\_

Group or Plan # \_\_\_\_\_

Insured's Name \_\_\_\_\_

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

Insured's Birthdate \_\_\_ / \_\_\_ / \_\_\_ SS# \_\_\_\_\_

Insured's ID # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**Secondary**

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_) \_\_\_\_\_

Group or Plan # \_\_\_\_\_

Insured's Name \_\_\_\_\_

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

Insured's Birthdate \_\_\_ / \_\_\_ / \_\_\_ SS# \_\_\_\_\_

Insured's ID # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

In the event of an emergency, is there someone who lives near you that we should contact?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ Wk# (\_\_\_\_) \_\_\_\_\_

**SPOUSE INFORMATION**

His/Her Name \_\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Cell#(\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_

Birthdate \_\_\_ / \_\_\_ / \_\_\_ CDL# \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Name \_\_\_\_\_

Billing Address \_\_\_\_\_

\_\_\_\_\_

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

SS# \_\_\_\_\_ CDL# \_\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

**MEDICAL HISTORY**

Do you have a personal Physician?    Yes    No

Physician's Name \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

Date of last visit \_\_\_\_\_

Are you currently under the care of a physician?    Yes    No

Please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## *Limited Dental Warranty*

People always ask us, "How long should this last?" In our office, we strive for perfection and satisfaction is why we are happy to provide you with this warranty, something few offices offer. You can prevent most or all disease if you spend 4 minutes in the morning and 4 minutes in the evening brushing, flossing, and doing other special treatments your dentist and hygienist have recommended. Recommended maintenance by your dentist and hygienist to have your teeth professionally cleaned is also extremely important. ***All warranties are null and void if we do not see you for your recommended maintenance appointments.***

- ***Composite Fillings***

When a tooth has a cavity, the dentist removes the decay and fills the hole with a composite (tooth-colored) filling. The tooth is what supports the filling. For a period of 2 years from the date of service, we will replace the composite filling, due to breakage, misfit or decay at no cost to the patient.

- ***Root Canal Therapy***

Does root canal therapy always work? No! A root canal is a therapy, not a cure. It has a high success rate, but 4% fail. If your root canal fails, we may send you to an endodontist to have it re-treated. If this is your case, for a period of 5 years from the date of service, we will refund the cost of the root canal therapy if it is due to failure. In addition, if the tooth cannot be saved, the cost of the crown and build up placed in our office will also be refunded during that 5-year period.

- ***Crown or Bridge***

Due to breakage, misfit, or decay for a period of 5 years from the date of service, we will replace or refund the cost of a crown or bridge, at no cost to the patient.

- ***Veneer***

Due to breakage, misfit, or decay for a period of 3 years from the date of service, we will replace or refund the cost of a veneer, at no cost to the patient.

- ***Implant Surgery***

A small number of patients do not respond successfully to dental implant surgery. Occasionally, implants fail due to infection. The success rates for dental implants are among the highest for any dental procedure (around 95%), however failures do occur. If an implant fails, it needs to be removed and it may be subsequently replaced. Due to failure or infection of an implant, we will replace or refund the cost of the implant, at no cost to the patient, for a period of 1 year from the date of service. If the implant fails after 1 year from the date of service, the patient will be responsible for half of the cost of the implant and crown replacement. After 2 years, the patient is responsible for 75% of the cost of the implant and crown replacement. If the implant fails after 3 years, the patient is responsible for the entire cost of the implant and crown.

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**Patient Signature**

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**Date**

***All warranties explained above are null and void if the patient does not comply with their recommended Hygiene appointments.***

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you  
Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs  
 Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

## Financial Policy

Thank you for choosing Nash Dental Care. We realize that every person's financial situation is different. For this reason, we have worked very hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. In order to meet your needs, we need your assistance and your understanding of our payment policy.

**Payment for services is due at the time services are given (including insured person's portion).**

For your convenience, we accept cash, checks, Visa, Mastercard, American Express or Discover Card. We also offer no interest payment plan through Care Credit & other outside financial groups (terms apply) and pre-payment courtesies. We will be happy to help you process your insurance claim forms at no additional cost and we will accept assignment of benefits where allowed. However, we must have your completed insurance form, copy of your insurance card and a provider benefit booklet at your first visit.

**Broken Appointments:** A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require 48 hours notice to avoid a \$35.00/hour or 10% of treatment total (which ever is greater) cancellation fee (emergencies are an exception).

Account balances older than 60 days and returned checks will be subject to an interest charge of 1 ½% per month. There is a \$30.00 charge for returned checks.

We will gladly discuss your proposed treatment and answer any questions relating to **your insurance**. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most Companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, 80%) of "U.C.R." which means usual, customary and reasonable by most companies. (This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must have a benefit booklet to help you determine your benefits.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such a problem should arise, we ask you contact us immediately.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask. We are here to help you.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read the above information and understand and agree to the content.

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**Signature**

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**Date**

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**Signature of Parent of Guardian (if patient is a minor)**

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**Date**

## PATIENT INFORMATION

NAME	DATE TODAY / /	AGE	SEX	TELEPHONE
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Please review and answer all parts of each question with our staff. Provide specific details/notes in the righthand column.

#	QUESTIONS	ANSWERS		NOTES - LIST QUESTION #, THEN DESCRIBE SYMPTOM DETAILS
1	Have you noticed a change in your bite? » Do you feel like your teeth hit first on the right or left side? <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT » Do you hit more on the front teeth or more on the back teeth? <input type="checkbox"/> FRONT <input type="checkbox"/> BACK	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
2	Are you aware of any of the following: Popping/Clicking Grinding Noise in the Jaw Joints	<input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO	
3	Do you have difficulty or pain <input type="checkbox"/> opening wide <input type="checkbox"/> chewing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4	When you wake up, do your jaw joint or muscles feel tight or sore?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
5	Do you snore at night?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
6	Does your jaw joint or muscles feel stiff, tight or tired after eating?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
7	Do you grind or clench your teeth <input type="checkbox"/> at night <input type="checkbox"/> during the day?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
8	Do your gums bleed after <input type="checkbox"/> brushing <input type="checkbox"/> flossing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
9	Do you experience pain in your:	Jaw <input type="checkbox"/> YES Face <input type="checkbox"/> YES Neck <input type="checkbox"/> YES Shoulder and/or Arms <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO	
10	Do you get <input type="checkbox"/> headaches <input type="checkbox"/> migraines? » If Yes, what time of day do they occur? <input type="checkbox"/> MORNING <input type="checkbox"/> AFTERNOON <input type="checkbox"/> NIGHT <input type="checkbox"/> ANYTIME » How many headaches (H) and migraines (M) each week? ____ (H) / ____ (M) Each month? ____ (H) / ____ (M) » What medications do you take to relieve them? _____ » How long do they last without medications? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
11	Do you have any <input type="checkbox"/> ringing <input type="checkbox"/> fullness in your ears?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
12	Do you ever get <input type="checkbox"/> dizzy <input type="checkbox"/> sea sick?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
13	Do you ever feel <input type="checkbox"/> anxiety <input type="checkbox"/> stressed? » How would you rate your stress level? <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
14	Have you had braces or orthodontic treatment? » If Yes, when did you finish your treatment? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
15	Have you ever worn a <input type="checkbox"/> bite splint <input type="checkbox"/> retainer? » If Yes, when did you have this treatment? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
16	Have you ever had a <input type="checkbox"/> car accident <input type="checkbox"/> trauma to your head? » If Yes, describe and list dates: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
17	Have you ever had any sports injuries? » If Yes, describe and list dates: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
18	Do you restrict or avoid normal activities due to pain or symptoms? » If Yes, describe activities: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
19	Do you spend 4+ hours working at a desk or using a computer daily?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

Scoring: 1-3 "Yes" Responses = Mild unbalanced bite | 4-6 "Yes" Responses = Moderate unbalanced bite | 7+ "Yes" Responses = Severe unbalanced bite

When finished, please return to our office and review your answers with our staff.