ABOUT PATIENT (MINOR)

All information required.

Today's Date _____

Name _____

I prefer to be called _____M____F_____

Birthdate ___/___/_____ SS# _____

Home Address _____

City_____Zip_____

PARENT / GUARDIAN INFORMATION

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 _____

Where and when are the best times to reach you?

_____

How did you hear about our office?

_____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____

Billing Address _____

_____

Relationship to Patient _____

SS# _____ CDL# _____

Employer _____

Work # (____)_____ Cell# (____)_____

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# (____)_____

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 _____

_____

_____

Continue to Medical History Form…

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.

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

_____ _____

Signature **Date**

_____ _____

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