Thank you for choosing our dental team!

Date:_____

Name: _____ Married Single Child
Last First Middle Initial Please Circle one

Address: _____
Street address (no PO Box) City State Zip

Birth date: _____ Social Security #:_____

Home Phone: _____Pager/Cell: _____ E-Mail: _____

Employer: _____ Phone: _____

In Case of Emergency Call: Name: _____ Phone: _____

Your Physician's Name: _____ Phone: _____

Medical Status:

Have you ever had, or now have……

____ Cancer	_____ High blood pressure	____ Low Blood Pressure
____ Diabetes	_____ HIV virus or AIDS	____ Stomach Ulcers
____ Controlled by diet	_____ Hepatitis	____ Prone to Mouth Ulcers
____ Controlled by insulin	_____ Epilepsy or Seizures	____ Fainting or Dizziness
____ Stroke	_____ Asthma	____ Excessive Bleeding
____ Heart Disease	_____ Mitral Valve Prolapse	____ Artificial Joint Replacement

Are you being treated for any health problems? _____ If so, please list problems: _____

_____.

Women : Are you pregnant? _____ If so, Physician's Name: _____

Please list any medications you are now taking: _____

Please list any drug allergies you now have: _____

Referral Information

Whom may we thank for referring you to our office? _____

____Television Ad ____Internet ____ Radio _____ Yellow Pages ____ Friend ____ Relative

" A Smile is worth a thousand words."

Dental Status

******Preventive Care***

Yes No Are regular exams and preventive care a priority for you?

Yes No Have you had a complete exam (x-rays, periodontal exam, bite evaluation, oral cancer screening) within the past two years?

******Periodontal (gums) and TMJ (jaw joints)***

Yes No Do your gums bleed?

Yes No Have your gums receded?

Yes No Have you noticed any loose teeth?

Yes No Have you had periodontal (gum) surgery?

Yes No Have you noticed a bad taste or odor?

Yes No Do you have jaw pain?

Yes No Does your jaw click or pop?

****** Fillings, Crowns, Bridgework***

Yes No Do you have any crowns or bridgework?

Yes No If yes, are you satisfied with them?

Yes No Does food become trapped between any of your teeth?

Yes No Would you say that you have a ___high ___ low ___moderate susceptibility to cavities.

****** Cosmetics and Orthodontics***

Yes No Do you prefer white (bonding) fillings to amalgam(silver, mercury)fillings?

Yes No If it were possible would you want to change the appearance of your smile?

____whiter ____ better shape ____ Replace old mercury fillings

____ Replace old crowns

****** For Your Comfort***

Yes No Do you feel nervous about dental treatment?

Yes No Do you prefer to use nitrous oxide (laughing gas) during dental treatment?

Note: There is a nominal fee for this service. Please ask a staff member for details.

Yes No Would you like to use head phones with music during treatment?

******Today, my primary concern is:***

____ *Exam/Diagnosis* ____ *Preventive (cleaning)* ____ *Emergency* ____*Consultation*

Comments: _____.

_____.

Insurance Information

As a courtesy to you, we will file your insurance claims for you.
In order to do this, we need you to provide the following:

***A copy of your benefits pamphlet (obtain from your human resources department)**
***Information to verify coverage, eligibility, etc.**
***A photocopy of your primary and secondary insurance cards**

PLEASE NOTE:

DENTAL INSURANCE COVERS ONLY A PORTION OF YOUR TREATMENT COSTS. PLEASE BE PREPARED TO MAKE FULL PAYMENT FOR YOUR ESTIMATED PORTION, NOT COVERED BY INSURANCE, ON THE DAY OF TREATMENT.

Primary Insurance: _____ Employer: _____ Group # _____

Insured name: _____ Birth date: _____ SS#_____

Secondary Insurance: _____ Employer: _____ Group# _____

Insured name: _____ Birth date: _____ SS# _____

Payment Options

In an attempt to provide our patients with the best dental care possible we offer a variety of payments options. **PLEASE SELECT THE ONE THAT BEST SUITS YOUR NEEDS FOR FULL PAYMENT OR FOR THE PORTION NOT COVERED BY INSURANCE.:**

- ☐ **Personal Check or Cash**
- ☐ **Credit/Debit card**
- ☐ **Care Credit***
- ☐ **Capital One Plan****

*****Care Credit is a special plan that offers up to 12 months interest free financing- certain limitations may apply.
**Capital One Plan is specially designed for extensive treatment, please ask our financial assistant for details.

Non-Covered and Partially Covered Services:

Typically services involving outside laboratory work (crowns, partials, inlays, on lays, etc.) are not fully covered by Insurance, and Insurance Companies make no allowances for the premium laboratories we use. Also, a number of services involving cosmetics, medications for treating gum disease, bite equilibration, removal of old crowns, etc. have no insurance coverage.

We will advise you regarding the cost of the partially covered and non-covered services involved in your treatment plan which may include services for which we do not accept the suggested fee of your insurance plan.

Payment Agreement

<u>This section must be completed by the person responsible for payment of dental treatment.</u>

Responsible person's full name: _____Birth date_____

Address: _____ City _____ State_____ Zip_____

Home Phone _____ Social S. # _____

Employer _____ How long? _____ Work Phone: _____

Relationship to patient: _____

<u>Consent for Services</u>: As a condition of your treatment by this office, financial arrangements must be made in advance. **<u>All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services are performed.</u>** We also may need to send your dental records to an insurance company or to another dental / medical office as part of your treatment.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all services not paid within 90 days. I understand that I am solely responsible for all charges and attorney fees if suit be instituted thereunder. I also grant my permission to you or your assignee to telephone me at home or work to discuss matters related to this form. If this account should be sent to collections, I understand there will be a fee of 30% of my total balance.

<u>Appointments:</u> **Your appointment time is a time reserved just for you**. If you need to change your appointment we ask that you advise us two days prior so that another patient may be scheduled for that time. **<u>A broken appointment fee may be charged if sufficient notice is not provided.</u>**

Would you like a courtesy reminder from us to confirm your appointments? __ yes __ no
If yes, Call at: ____ home ____ work ____ E-mail (address)_____
Fax (number) _____
Best time to call: ____ AM _____PM _____Evenings

<u>Photographs</u>: Our doctors often use photographs, images and slides to illustrate various problems and solutions to other patients, insurance companies and other colleagues. Their experience and reputation in cosmetic dentistry also affords the opportunity to share the latest treatment techniques with civic and study groups.

<u>MY SIGNATURE ACKNOWLEDGES THAT:</u>

- Photographs of me may be used for educational purposes as stated above.
- I understand the office policy regarding missed appointments and delinquent accounts.
- I have selected and agreed to the payment option that best suits my needs.

Name _____ Date_____

MUST BE SIGNED BY RESPONSIBLE PARTY