Patient Information

Patient Legal Name: ______________________________ Date: ____________
Last, Legal First MI (Preferred Name)

Gender: ______________________________ Email: ______________________

Social Security #: ______________________ Birth Date: ________________

Phone (Home): ____________ (Work): ____________ Ext: ________ Cell Phone: ____________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ______________ Reason for this visit:

Have you ever had any of the following? Please answer by circling yes or no:

Yes / No AIDS
Yes / No HIV (+)
Yes / No Allergies
____

____
Yes / No Metal allergy
Yes / No Anemia
Yes / No Arthritis
Yes / No Artificial Joints
Yes / No Asthma
Yes / No Blood Disease
Yes / No Cancer
Yes/ No taking Bisphosphonates
Yes / No Chemotherapy
Yes / No Diabetes/Hypoglycemia
Yes / No Dizziness
Yes / No Epilepsy
Yes / No Excessive Bleeding

Yes / No Fainting
Yes / No Glaucoma
Yes / No Growths
Yes / No Hay Fever
Yes / No Head Injuries
Yes / No Heart Disease
Yes / No Heart Murmur
Yes / No Mitral Valve Prolapse
Yes / No Hepatitis
Yes / No High Blood Pressure
Yes / No High Cholesterol
Yes / No Jaundice
Yes / No Kidney Disease
Yes / No Liver Disease
Yes / No Mental Disorders
Yes / No Nervous Disorders
Yes / No Pacemaker

Yes / No Pregnancy
Due date:__________
Yes / No Radiation Treatment
Yes / No Respiratory Problems
Yes / No Rheumatic Fever
Yes / No Rheumatism
Yes / No Sinus Problems
Yes / No Stomach Problems
Yes / No Stroke
Yes / No Tuberculosis
Yes / No Tumors
Yes / No Ulcers
Yes / No Venereal Disease

Yes / No Codeine Allergy

Yes / No Penicillin Allergy
Yes / No Autoimmune Disorders
Yes / No Menopause
Yes / No Osteoporosis with Medication ____________
Yes / No Latex sensitivity
Yes / No Taken the prescription fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux) or any other weight control medication.
Yes / No Hyperthyroidism
Yes / No Hypothyroidism
List Current Medication:
____
____
____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

Dental Information

- When was your last dental visit? ______________________________
- How long ago were your last check-up x-rays taken? ______________________________

- Have you lost any teeth or have any teeth been removed recently? ☐ yes ☐ no
  If so, how long have they been missing? ____

- Do have any dentures, removable partial dentures, or fixed bridges? ☐ yes ☐ no
  If so, how old are they? ____

- Do you clench or grind your teeth? ☐ yes ☐ no

- Have you ever had any gum treatment or surgery? ☐ yes ☐ no
  If so, how long ago? ____

- Do you like the appearance of your teeth, your smile? ☐ yes ☐ no
  If not, explain____

- Are you pleased with the shape and color of your teeth?

- Are your teeth all in alignment (straight)? ☐ yes ☐ no
  If not, explain____

- Do you feel your teeth are too short? Too Long? ☐ yes ☐ no

- Do you have spaces that you don't like? ☐ yes ☐ no
  If not, explain____

- Are there old fillings or dental work that you don't like looking at? ☐ yes ☐ no
  If yes, explain____

- Are you unhappy with any silver mercury fillings in your teeth? ☐ yes ☐ no

- What would you like to change the most in the appearance of you teeth?
  ____

- How would you like your teeth to look? (whiter, straighter, longer, etc.)
  ____

Please Check Areas of Interest:

- ☐ Zoom In-Office Whitening
- ☐ Cosmetic Porcelain Laminate Veneers
- ☐ Cosmetic Replacement of Old Silver Amalgam Fillings
- ☐ Replacement of Missing Teeth with Dental Implants
- ☐ Consultation on Options to Improve Your Smile
- ☐ Invisialign

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Our office has an appointment cancellation policy where failure to show or a shorter than 24 hour notice of cancellation will result in a fee.

____ Date: ____________________
Signature of patient, parent or guardian

____ Date: ____________________
Signature of Dentist

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ____________________

Name of person or office referring you to our practice: ____

Spouse or Responsible Party Information

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

Legal Name: _, ________________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): ________________ (Work): ________________ Ext: ______ Email: ____________________

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 Phone

Insurance Information

Primary

Legal 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: ____

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Secondary

Legal 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: ____

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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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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 payment and agree to their content.

____ Date: ____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

____ Date: ____________ Relationship to Patient: ____________________
Signature of guarantor of payment/responsible party

Our Valued Clients,

Because every good relationship starts and continues with good communication, we want to provide some information about our dental practice.

Our mission statements: to work together as a team to provide compassionate and comprehensive oral care to every client; to thoroughly educate everyone on their oral health and preventative care; to use the latest dental advances to make your visits as comfortable and worry-free as possible; and to have every patient finish with a healthy, beautiful smile and be completely satisfied with their experience.

In order for us to provide the best, long-lasting dental care, we use only the finest products available and continually investing in the latest dental equipment. Also, our team is well trained and we continue our annual dental education and training to further enhance your experience at our dental office. Many of our dental services include employing CEREC technology to offer the option of same day crowns and veneers, Invisalign Orthodontics, Zoom whitening plus many more.

To preserve our commitment to excellence in dental care, we have a few policies that allow us to maintain the value in the services to you. We realize and respect that your time is very valuable and work very hard to make sure you are seen at your appointed time with little or no waiting. We do not double book any of our patients and do our best to accommodate your appointment needs. We require 24 hours notice of your need to change or cancel your appointment and a fee will be applied to your account if you fail to arrive for your appointment without notice or arrive significantly late that could unfairly affect the next patient's appointment. We understand that things happen and are unavoidable. With reasonable notice, we will do our best to make arrangements for your needs without applying the fee. We have a current list of patients waiting for appointment openings and this policy will help facilitate their needs as well as yours.

As a service to you, we will bill your applicable dental insurance, if you have provided all the necessary information. We make every effort to acquire the correct fees and co-payments so that you will be informed of your financial responsibilities prior to your dental services. We require your estimated fees, portions or co-payments to be paid at the time of service. Every type of credit card is accepted with no additional service fee. Financial arrangements extending beyond the time of service needs to be set forth prior to your appointment and is only available for certain services. For any residual balances after all insurance claims and payments are received, a billing statement will be sent to you with a 30 day grace period. Any credit amounts will be promptly issued. If you need any assistance in understanding the insurance payments, please call and one of our team members will be happy to assist you.

Thank you for your patience and understanding of our policies. They will help insure that you and all of our clients receive the upmost care that you deserve. Please sign below to confirm your acknowledgement of our policies.

Thank you.

Signature: ______________________________________

Date:____