radiant smiles
DENTISTRY
Keith F. Anderson, D.M.D.,P.C.

WELCOME TO OUR PRACTICE

PATIENT

Last Name First Name Middle Initial Preferred Name Title (if applicable)

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone_____ Email_____

Sex ___ M or F____ Birthday_____ Marital Status_____

Social Security #_____

Employer_____ Work Phone_____ Occupation_____

In case of Emergency, who should be notified?_____

Relationship to Patient_____

RESPONSIBLE PARTY

Last Name First Name Middle Initial Preferred Name Title (if applicable)

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone_____ Email_____

Sex ___ M or F____ Birthday_____ Marital Status_____

Social Security #_____

Employer_____ Work Phone_____ Occupation_____

How would you like us to contact you to confirm appointments?

Cell Phone_____ Home Phone_____ Email_____

HOW DID YOU HEAR ABOUT US?

Please let us know how you heard about our practice?

_____

DENTAL INSURANCE INFORMATION

Name of Insurance Policy Holder_____

Last Name First Name Middle Initial

Birth Date_____ Social Security #_____ Employer_____

Insurance Carrier_____ Phone_____ Group #_____

MINOR/CHILD CONSENT

I, being the parent or guardian of_____ (Name of Minor Child) do hereby request and authorize the dental staff to perform necessary services for my child, including but not limited to X-rays, and the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Patient, Parent or Guardian Signature_____ **Date**_____

(Must be 18 years or older to sign)

DENTAL HISTORY AND CONCERNS

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Radiant Smiles Dentistry focuses on providing comprehensive dental care to adults and their families. We strive to deliver care that improves our patient's oral health in an atmosphere of comfort and relaxation.

What is your chief complaint?_____
Does floss shred when you use it? Yes No
Does food pack or catch between your teeth? Yes No
Do you smoke or chew tobacco? Yes No
Do your gums bleed when you brush or floss? Yes No
Does your breath concern you? Yes No
When was your last dental appointment and cleaning?_____

How would you rate your smile? (Lowest) 1 2 3 4 5 6 7 8 9 10 (Highest)
Is there anything about your smile you would like to change?_____
Are you interested in learning how we may be able to straighten your teeth? Yes No

Please indicate if you have any of the following concerns (check all that apply):

- ❑ My teeth are not in alignment
- ❑ I have spaces I don't like
- ❑ I do not like the color of my teeth
- ❑ Chipped teeth
- ❑ Protruding teeth
- ❑ Hidden or missing teeth
- ❑ Old Fillings, Veneers or Crowns
- ❑ TMJ Discomfort
- ❑ Overall appearance of my smile

Have you ever been told or are you aware that you snore? Yes No

What is your reason for trying a new dental office?_____
_____
_____

Are there any additional concerns you would like us to know about?_____
_____
_____

MEDICAL HISTORY

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Although as dentists we treat the area in and around the mouth, it is a part of your entire body. Medical health problems that you may have, or medications that you may be taking, could be important to your dental health. Thank you for thoroughly answering the following questions.

Family physician_____ Phone_____

Are you taking any medication now, including regular dosages of aspirin? Yes No

If so, please list name and dosage_____

Are you aware of having an allergic reaction to any medication or substance? Yes No

If so, please list (e.g. Latex, Penicillin, Iodine)_____

Have you been under the care of a medical doctor during the past two years? Yes No

If so, for what condition?_____

Have you ever had heart surgery, heart valve or joint replacement, or organ transplant? Yes No

If so, for what and when?_____

Do you require pre-medication (e.g. knee or joint replacement)? Yes No

If so, for what?_____

Do you or have ever taken Fosamax or any other bisphosphonate, Zometa, Aredia, Boniva or Actonel? Yes No

Women: Are you ❑ Pregnant? ❑ Nursing? ❑ Taking Birth Control Pills? ❑ None

Have you seen an ENT (ear, nose and throat doctor)? Yes No Name_____

Have you seen a Neurologist? Yes No Name_____

Please indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item

Heart Concerns	Yes	No	Neurological Disorders	Yes	No	Headaches	Yes	No
Congenital Heart Disease	Yes	No	Osteoporosis	Yes	No	Limited Mouth Opening	Yes	No
Heart Murmur	Yes	No	Liver Disease/Jaundice	Yes	No	Ringing Ears	Yes	No
High Blood Pressure	Yes	No	Sickle Cell Disease	Yes	No	Facial Pain	Yes	No
Mitral Valve Prolapse	Yes	No	Asthma	Yes	No	Sensitive Teeth (hot/cold)	Yes	No
Artificial Heart Valve	Yes	No	AIDS/HIV	Yes	No	Difficulty Swallowing	Yes	No
Pacemaker	Yes	No	Stroke	Yes	No	Tingling in arms/fingers	Yes	No
Latex Allergy	Yes	No	Angina	Yes	No	Jaw Clicking/Popping	Yes	No
Artificial Joints	Yes	No	Anemia	Yes	No	Dizziness	Yes	No
Kidney Trouble	Yes	No	Ulcers	Yes	No	Posture Problems	Yes	No
Radiation/Chemotherapy	Yes	No	Tuberculosis	Yes	No	Trigeminal Neuralgia	Yes	No
Epilepsy/Seizures	Yes	No	Arthritis	Yes	No	Bell's Palsy	Yes	No
Hepatitis	Yes	No	Difficulty Chewing	Yes	No	Jaw Pain	Yes	No
Psychiatric Disorders	Yes	No	Insomnia/Nervousness	Yes	No	Congested Ears	Yes	No
Diabetes	Yes	No	Teeth Clenching/Grinding	Yes	No	Loose Teeth	Yes	No
Thyroid Disorder	Yes	No	Snoring/Sleep Apnea	Yes	No	Neck Ache	Yes	No

Notes/Any other health issues?_____

Medical Updates_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify Radiant Smiles doctors or staff of any changes in any health or medication.

Patient, Parent or Guardian Signature_____ **Date**_____

(Must be 18 years or older to sign)

FINANCIAL POLICY/PAYMENT OPTIONS

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At Radiant Smiles Dentistry, we never want to trade a dental problem for a financial problem. Therefore, we provide a range of payment options for our patients.

CHECK, DEBIT CARD, VISA®, MASTERCARD®, DISCOVER® Card are all accepted methods of payment.

DENTAL PAYMENT PLAN (Monthly payment plans including no-interest and extended period plans)

Flexible monthly payment plans are available from third party companies such as Care Credit and Citi Financial (the "Financing Companies"), subject to credit approval.

INSURANCE PLANS

We accept many dental plans, and we will work to maximize your dental benefits and submit your insurance claims at no charge. For you convenience, we accept the insurance benefits directly from your insurance company, and only the estimated portion not covered by your insurance is due at the time treatment is performed. However, we make no guarantees of your insurance reimbursement, and if we do not receive payment in full from your insurance company within 60 days, you will be responsible for the unpaid insurance portion.

Assignment and Release: You, the undersigned, assign directly to Keith F. Anderson, DMD, PC, i.e.: Radiant Smiles Dentistry, all benefits, in any, otherwise payment to you for services rendered. You hereby authorize the use of your signature on all your insurance submissions, whether manual or electronic.

FLEXIBLE SPENDING ACCOUNTS

We accept payments from most FSA and HSA accounts for approved dental treatments.

PLEASE NOTE

We require payment or a financial arrangement before the start of your treatment.

Your appointments have been reserved exclusively for you. If you are unable to come for your appointment, ***please notify our office staff at least 24 hours in advance***, so that we may offer that availability to another patient in need of treatment. If you cancel your appointment with less than 24 hours notice or are late for your appointment such that your scheduled treatment cannot be completed, your account will be charged a $35 cancellation fee.

For your protection, and to constantly improve the quality of care we deliver, phone calls to our office may be recorded.

There will be a $25 charge for all returned checks.

If it would ever become necessary to have a third party assist Radiant Smiles Dentistry in the collection of an account debt, any costs incurred related to that third party collection effort would be advanced to your account.

I have read the Financial Policy in its entirety and I understand and agree to all its terms and conditions.

Patient, Parent or Guardian Signature_____ **Date**_____

(Must be 18 years or older to sign)