Patient Information

Patient Name: _____ Date:_____
Last First (Preferred Name) MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Student _____ ☐ Other_____
School/Grade

Social Security #: _____ Birth Date:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext:_____ Cell:_____

How would you like us to remind you of your appointments: Circle all that apply: Text Email Phone (C, H, W)

Emergency Contact: (Name & Nunber) _____ # _____

Drivers License #_____Email Address:_____

Employer:_____Occupation/Posiiton:_____

Dental Insurance (Primary)_____Secondary:_____

Spouse or Responsible Party Information

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

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information

Primary

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:

_____

Secondary Insurance ☐ YES ☐ NO

Referral Information

Whom may we thank for referring you? ☐ Online/Website ☐ Another patient ☐ Another Office ☐ Phonebook

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

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Emphysema	☐ Jaundice	☐ Respiratory Problems
☐ Anemia	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Angina	☐ Excessive Bleeding	☐ Liver Disease	☐ Rheumatism
☐ Arthritis	☐ Fainting	☐ Low Blood Pressure	☐ Seizures
☐ Venereal Disease	☐ Glaucoma	☐ Lupus	☐ Sinus Problems
☐ Asthma	☐ Hay Fever	☐ Mental Disorders	☐ Stomach Problems
☐ Blood Disease	☐ Headaches	☐ Mitral Valve Prolapse	☐ Stroke
☐ Blood Transfusion	☐ Heart Attack	☐ Nervous Disorders	☐ Thyroid Problems
☐ Cancer	☐ Heart Disease	☐ Pacemaker	☐ Tuberculosis
☐ Congen. Heart Defect	☐ Heart Murmur	☐ Pregnant Currently	☐ Ulcers
☐ Diabetes	☐ Hepatitis	Due date:_____	☐ Artificial Joints/Valves
☐ Dizziness	☐ High Blood Pressure	☐ Radiation Treatment	Date Placed_____

- Are you allergic or had negative reactions to any of the following? ☐ Local Anesthetics ☐ Penicillin ☐ Sulfa Drugs ☐ Barbiturates ☐ Sedatives ☐ Codeine ☐ Aspirin ☐ Latex ☐ Metals/Jewelry ☐ Please list any others:
- Are you currently using any kind of Tobacco? (including smokeless)? ☐ Yes ☐ No How much per day?_____
- Did you formerly use any kind of Tobacco? (Cigarettes or smokeless) ☐ Yes ☐ No How long ago? _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list:_____
  _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you currently under the care of a physician? ☐ Yes ☐ No

- Name of Physician: _____ Phone:_____

- Name of Physician: _____ Phone:_____

Dental Information

Date of Last Dental Visit: _____ Reason for this visit:_____ Previous Dentist:_____

Yes	No	
☐	☐	Do you need to take an antibiotic premedication prior to dental treatment?
☐	☐	Do you have problems with dry mouth?
☐	☐	Are you satisfied with the appearance of your teeth?
☐	☐	Are you satisfied with the function of your teeth?
☐	☐	Are your teeth sensitive to hot/cold, or sweets?
☐	☐	Have you been told that you have periodontal disease?
☐	☐	Have you ever had any complications following dental treatment?
☐	☐	Does food frequently get caught between teeth?
☐	☐	Do your gums often bleed while brushing?
☐	☐	Have you noticed your teeth getting loose?
☐	☐	Have you injured your head, neck, or jaw?
☐	☐	Is it important for you to keep your teeth?

Yes	No	Problems of the jaw – Have you noticed:
☐	☐	Clicking of the Jaw?
☐	☐	Pain (joint, ear, side of face)?
☐	☐	Difficulty opening or closing?
☐	☐	Difficulty chewing?

Yes	No	Oral habits: Do you:
☐	☐	Clench or grind your teeth?
☐	☐	Bite your lips or cheek frequently?

Yes	No	Have you had:
☐	☐	Orthodontic treatment (braces)?
☐	☐	Oral surgery?
☐	☐	Gum tissue treatment?
☐	☐	A bite guard/snore appliance?

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.

_____ Date: _____

Signature of patient, parent or guardian

Acknowledgement of Receipt - Notice of Privacy Practices

I have been offered, received and/or read a copy of this.

Cancellations and Missed Appointments

Your appointment time is reserved specifically for you and for you only. Because of this, missed appointments or late cancellations are extremely detrimental to our day. As a result, we request at least 24 hours advanced notice if you will not be able to make your appointment. Repeated missed appointments or late cancellations may result in fees or dismissal as a patient.

Agreement to Payment

Patients are expected to make financial arrangements in advance of treatment. 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.

Discounts and Payment Options: Payments may be made using Cash, Check, Credit Card, Care Credit, and Proceed Finance. Patients who pay their entire balance on the day of service will receive a 5% discount.
Insurance: As a courtesy to you, we will help you process all your dental insurance claims and will assist in collecting from your insurance carrier. We will provide you with the most accurate insurance estimate possible; however, we do not guarantee that your insurance will pay exactly as estimated. We ask that you pay the deductible, and co-payment at the time that we provide the service to you. The patient understands that he or she is personally responsible for payment of all dental services.

Emergencies: All emergency patients, new to our practice, are expected to make full payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.
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. 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.

Consent for Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by our office. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.
Please do not consent to treatment until you discuss potential benefits, risks, and complications with your dentist or hygienist and all of your questions are answered. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
It is very important that you provide our office with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medications, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice given by our office, you may increase the chances of a poor outcome.

I have read the above conditions of treatment and payment and agree to their content.

Signature _____ Date