

WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION						
Last Name	First	M.I.	Preferred Name			
Street Address		Birthdate				
City	State	ZIP				
Social Security No.	E-mail Address					
Home Phone	Work Phone		Cell Phone			
How would you like to receive appointment reminders? (circle one)		Home call	Cellular call	Text message	E-mail	
Employer	Marital Status:		Single	Married	Divorced	Widowed
In Case of Emergency Contact:			Relationship:			
Emergency Home Phone:			Emergency Work Phone:			

DENTAL INSURANCE (Primary Carrier)	DENTAL INSURANCE (Secondary Carrier)
Insured's Name	Insured's Name
Insured's Employer	Insured's Employer
Insurance Company	Insurance Company
Insured's DOB	Insured's DOB
Insured's SS#	Insured's SS#
Subscriber ID #	Subscriber ID #

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

- Payment is due at the time service is provided.
- Our office accepts cash, personal checks, Visa, Mastercard, and Discover.
- Outside financing is available through CareCredit. We will assist you with this if needed.
- Returned checks will be subject to additional fees.
- In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges.
- As a courtesy to you we will file all insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated.
- All charges you incur are your responsibility regardless of your insurance coverage.
- We kindly request at least 24 hours notice for any cancellation. If we are not given 24 hours notice, you will be charged a \$30 missed appointment fee.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Patient Signature (Guardian if child)

Date

DENTAL HISTORY

	YES	NO		YES	NO
Please check any of the following problems that apply to you.			Do you smoke or use chewing tobacco?		
-Sensitivity (hot, cold, sweet)			How much? _____ How long? _____		
-Headaches			If I could change my smile, I would:		
-Jaw joint pain			-Make it whiter		
-Broken teeth or fillings			-Make it straighter		
-Grinding or clenching teeth			-Close spaces		
-Loose or shifting teeth			-Replace old crowns that don't match		
-Bad breath			-Repair chipped teeth		
Do you have or have had any of the following?			-Replace missing teeth		
-Dentures			-Replace black metal fillings with white tooth colored fillings		
-Partial dentures			-Have a smile makeover		
-Braces			Previous Dentist & Location:		
-Periodontal (gum) treatment					

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS			Drug Addiction			Jaw Pain			Sleep Apnea		
Allergies (Seasonal)			Emphysema			Kidney Disease			Stomach Problems		
Anemia			Epilepsy			Liver Disease			Stroke		
Angina (Chest pain)			Excessive Bleeding			Low Blood Pressure			Thyroid Disease		
Arthritis			Fainting			Mitral Valve Prolapse			Tuberculosis		
Artificial Heart Valve			Glaucoma			Nervousness/Depression			Ulcers		
Artificial Joints			Heart Conditions			Pacemaker			Venereal Diseases		
Asthma			Heart Lesions			Pregnant Currently			Other:		
Blood Disease			Heart Murmur			Radiation (head/neck)					
Bruise Easily			Heart Surgery			Respiratory Problems					
Cancer			Hepatitis			Rheumatic Fever			Surgeries(last 3 yrs)		
Chemotherapy			High Blood Pressure			Rheumatism					
Cortisone Medication			HIV Positive			Scarlet Fever					
Diabetes			HPV			Seizures					
Dizziness			Jaundice			Sinus Problems					

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO
Aspirin			Latex			Penicillin		
Codeine			Local anesthetic			Sulfa		
Erythromycin			Nitrous oxide			Other allergies _____		

Have you ever taken any of the following medications?

	YES	NO		YES	NO
Actonel			Zometa		
Aredia			Boniva		
Fosamax			Other Bisphosphonate		
Reclast			Herbal Supplements		

What medications/doses/frequency are you currently taking? _____

Consent:

The undersigned hereby authorizes Doctor to take X-rays, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any treatment, medication and therapy indicated. I also understand the use of anesthetic agents embodies a certain risk. I attest that the above medical history is true and I have disclosed all medical conditions to the Doctor. I have read, understand and agree to the above terms and conditions.

Patient Signature (Parent if child)

Date

Dentist Signature