# Welcome!

*To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please ask someone at the front desk and we will be happy to help you. Thanks for being our patient!*

## Patient Information

Name ______________________________
Last First MI

Preferred Name ______________ Title __________

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

Date of Birth ____________ SSN ______________

Driver's Lic. ______________ State __________
*(photocopy required)*

Address ______________________________

______________________________
City State Zip Code

Home Phone ____________ Alternate Phone __________

Email ______________________________

Employer ______________ Wk Phone __________

Emergency Contact Name/Phone ______________

How did you hear about us? ______________

## Insurance Information

Insured Employee ______________________________

Insured's SSN ______________ DOB __________

Insurance Company ____________ Phone __________

Employer ______________ Group # __________

Insured's Relationship to Patient ______________

College (full-time students only) ______________

**Assignment and Release**

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

**X** ______________________________
Responsible Party Signature

______________________________ ______________
Relationship to Patient Date

## Office & Financial Policies

At least 48 hours is required for appointment changes or cancellations. Appointments cancelled with less than 48 hours notice incur a $50 charge; an additional $50 fee is charged for appointments with specialists.

Valid identification is required for all personal checks. Returned checks will be subject to the terms and conditions of the electronic check acceptance company used in this office, including any fees charged by that company.

Payment and/or Co-payment is required in full at the time services are rendered. In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that Medical/Dental Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned understands that the co-payment requested for services is only an ESTIMATE of what the insurance will not cover based upon information provided by the insurance company and NOT A GUARANTEE OF PAYMENT. The actual insurance benefit may differ from our estimates**. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY UNPAID BALANCE**

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I : { } **am** { } **am not** an active duty member of the U. S. Armed Forces.

**I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.**

______________________________ ______________
Responsible Party Signature Date

**Over Please...**

# Dental Health History

Name:______________________________

Reason for today's visit______________

______________________________

Former Dentist______________________

Phone______________________________

Date of last dental exam______________

Date of last dental x-rays______________

Date of last cleaning_________________

How often do you brush?______________

How often do you floss?_______________

Do you feel pain anywhere?____________

Describe____________________________

______________________________

**Circle "Yes" or "No" to indicate whether you have had any of the following conditions:**

| Condition | | |
|---|---|---|
| Sensitivity to hot or cold | Yes | No |
| Sensitivity to sweet | Yes | No |
| Avoid one side of the mouth when chewing | Yes | No |
| Sensitivity when biting | Yes | No |
| Broken / cracked fillings | Yes | No |
| Food collection between teeth | Yes | No |
| Tobacco use | Yes | No |
| Gums swollen or tender | Yes | No |
| Gums bleed frequently | Yes | No |
| Blisters on lips or mouth | Yes | No |
| Sores or growths inside cheek / in the mouth | Yes | No |
| Bad breath | Yes | No |
| Burning sensation on tongue | Yes | No |
| Dry mouth | Yes | No |
| Accident involving jaw | Yes | No |
| Clicking or popping jaw | Yes | No |
| Frequent headaches | Yes | No |
| Grinding teeth | Yes | No |
| Jaw pain or tiredness | Yes | No |
| Pain around ear | Yes | No |
| Orthodontic treatment | Yes | No |
| Periodontal treatment | Yes | No |

# Medical Health History

Physician______________________ Phone______________

Please list all current medications (include prescription, over-the-counter, herbal supplements) and reason for use:

______________________________

______________________________

______________________________

**Are you allergic to any of the following?**

☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Valium

Other:______________________________

**Have you ever had any of the following conditions?**

☐ Artificial joint/valve ☐ Heart murmur ☐ Mitral valve prolapse ☐ Rheumatic fever

**Women Only:**

| Question | | |
|---|---|---|
| Do you use birth control medication? | Yes | No |
| Are you nursing? | Yes | No |
| Are you pregnant? (Due date:_____________) | Yes | No |

**Circle "Yes" or "No" to indicate whether you have had any of the following conditions:**

| Condition | | |
|---|---|---|
| AIDS / HIV | Yes | No |
| Anemia | Yes | No |
| Arthritis or Back problems | Yes | No |
| Asthma or Respiratory problems | Yes | No |
| Blood transfusion (Date:_______________) | Yes | No |
| Cancer | Yes | No |
| Cardiac pacemaker | Yes | No |
| Convulsions / Epilepsy / Seizures | Yes | No |
| Diabetes | Yes | No |
| Excessive bleeding with surgery / extractions | Yes | No |
| Heart problems | Yes | No |
| Hepatitis or Liver problems | Yes | No |
| High or Low blood pressure | Yes | No |
| Kidney problems | Yes | No |
| Phen-Phen treatment | Yes | No |
| Radiation or Chemotherapy treatment | Yes | No |
| Stroke | Yes | No |
| Thyroid disorder | Yes | No |
| Tuberculosis | Yes | No |
| **Other:** | Yes | No |

______________________________

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

**X** Responsible Party Signature ______________________________ Date ______________

**X** Attending Dentist Signature ______________________________ Date ______________