ALL SPACES MUST BE FILLED OUT

Patients Name:_____ Preferred Name:_____

Gender: ☐ Male ☐ Female ☐ Other Date of Birth: _____ Age:_____

Address: _____ City: _____ State:_____ Zip:_____

Social Security Number:_____ Email:_____

Mobile Phone:_____ Home Phone:_____

Employer: _____ Occupation:_____ Work Phone: _____

Emergency Contact:_____ Relationship:_____ Phone Number:_____

Pharmacy Name & Location: _____

IF UNDER 18

Parent Name:_____ Parent SSN:_____

Parent Phone Number: _____ Parent Employer:_____

Reason For Today's Visit? _____

How did you hear about us? ☐ Internet/Online ☐ Drive By/Walk In ☐ Family Friend ☐ Insurance ☐ Social Media

INSURANCE INFORMATION

Policy Holder Name: _____ Policy Holders DOB: _____

Policy Holders SSN (We may ask for this to be able to efficiently locate insurance): _____

Policy Holders Employer: _____ Insurance Company Name: _____

Member/Subscriber ID: _____ Group #: _____

Insurance Co Street Address: _____ Insurance Company City: _____

Ins Company State: _____ Ins Company Zip: _____ Ins Company Phone # _____

MILITARY PATIENTS: If you have United Concordia/ Tricare, please provide the paygrade/rank of the active duty member: _____

SECONDARY INSURANCE INFORMATION

Policy Holder Name: _____ Policy Holders DOB: _____

Policy Holders SSN (We may ask for this to be able to efficiently locate insurance): _____

Policy Holders Employer: _____ Insurance Company Name: _____

Member/Subscriber ID: _____ Group #: _____

Insurance Co Street Address: _____ Insurance Company City: _____

Ins Company State: _____ Ins Company Zip: _____ Ins Company Phone # _____

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality 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, credit cards, or one of the third- party financing options we provide.

Please check if you would like more information about financing options ☐ Yes ☐ No

Do You Have Insurance?

• We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

• As a courtesy to you we will help you process all your 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. Your insurance company and your plan benefits will determine the amount paid. We will, of course, 3 of 8 do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

• We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

• We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, credit card or one of the third-party financing options we provide.

• We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

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

HIPAA and Financial Consent

We understand that medical information about you and your health is personal, and we are committed to protecting such information. For a detailed description of our privacy practices, please see our "Notice of Privacy Practices" at the front desk. This document also describes your rights and certain obligations we have regarding the use and disclosure of medical information. Other uses and disclosures of medical information not covered by this Notice, will be made only with your written permission. 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. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Please Note: 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.

Patient Signature/Legal Guardian: _____

DENTAL HISTORY

Patient Name:_____

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

Appearance:

☐ Discolored Teeth

☐ Flat/Worn Teeth

☐ Misshaped Teeth

☐ Crooked Teeth

☐ Crowding

☐ Spaces/Missing Teeth

☐ Deep Bite

Pain/Discomfort:

☐ Sensitivity

☐ Pressure/Pain with chewing

☐ Broken Teeth/Filling

☐ Dry Mouth

☐ Other

Function:

☐ Grinding/Clenching

☐ Morning Headaches

☐ Jaw Pain (TMJ)

☐ Jaw joint/clicking popping

☐ Speech Impediment

☐ Mouth Breathing

☐ Sore Muscles

☐ Difficulty opening or closing

Periodontal (Gum) Health:

☐ Bleeding/Swollen, irritated gums

☐ Bad breath

☐ Loose, tipped or shifting teeth

☐ Previous perio/gum disease

Sleep Patterns Conditions:

☐ Sleep Apnea

☐ Snoring

Habits:

☐ Thumb sucking

☐ Nail Biting

☐ Cheek/Lip biting

☐ Chewing on ice/objects

Previous Comfort Options:

☐ Nitrous Oxide

☐ Oral Sedation (Pill)

☐ IV Sedation

Frequent/ Daily Use:

☐ Soda/Sweet Tea

☐ Coffee with creamer/ sugar

☐ Sports/Energy Drinks

☐ Candy/Sweets

☐ High carb diet

SOCIAL

Tobacco packs per day: _____ Alcohol Frequency: _____ Drug Frequency:_____

Please share the following dates:

Last Dental Visit: _____ Last Cleaning: _____

On a scale of 1-10, with 10 being the highest rating:

Dental Anxiety _____ Happy with your smile: _____

MEDICAL HISTORY

Please check if you have/had any of the following:

Medical Allergies

☐ Antibiotics (Penicillin, Amoxicillin/ Clindamycin)

☐ NSAIDs

☐ Opioids

☐ Latex

☐ Local anesthetics

☐ Other: _____

Cancer:

☐ Chemotherapy

☐ Radiation

If cancer, type: _____

Respiratory

☐ Asthma

☐ Emphysema/COPD

☐ Respiratory Problems

☐ Sinus Problems

☐ **Sleep Apnea**

☐ Tuberculosis

Cardiovascular

☐ High Blood Pressure

☐ Pace maker

☐ Stroke

☐ Heart Surgery

☐ Heart Conditions

☐ Angina (chest pain)

Endocrinology:

☐ Diabetes

☐ Hepatitis A/B/C

☐ Kidney Disease

☐ Liver Disease

☐ Thyroid Disease

Gastrointestinal:

☐ Reflux

☐ Gastrointestinal Disease

Hematologic/Lymphatic

☐ Anemia

☐ Blood Disorders

☐ Bruise Easily

☐ Excessive bleeding

Neurological

☐ Anxiety

☐ Depression

☐ Dizziness/Fainting

☐ Drug/Alcohol addiction

☐ Seizures

☐ Psychiatric Illness

Viral Infections:

☐ AIDS

☐ HIV Positive

☐ HPV

☐ Cold Sores

Primary Care Doctor: _____ Phone Number: _____

Have you had a serious illness, operation or hospitalization the past 5 years? If so, explain:

_____

Please check if you have any of these conditions:

☐ Artificial heart valve ☐ Previous infective endocarditis ☐ Damaged heart valves in heart transplant

☐ unrepaired cyanotic CHD ☐ Repaired CHD with residual defects

Please list ANY medications currently taking: _____

_____

Have you ever in the past, or are you now currently taking any medications for osteopenia/osteoporosis or bone disease? If yes, please list medications: _____

Are you on blood thinners? If yes, please list: _____

Women:

Currently Pregnant: ☐ Yes ☐ No If currently pregnant, due date: _____

FOR PATIENTS WITH SPECIAL NEEDS/DISABILITIES, PLEASE CHECK ALL THAT MAY APPLY:

☐ Autism ☐ Down Syndrome ☐ Cerebral palsy ☐ Developmental Delay, if so please explain below

☐ ADD/ADHD ☐ Sensory issues, if so please explain below ☐ Speech Delay ☐ Non verbal

☐ Wheelchair/Walker/Walking device

Explain:

_____

_____

_____

If you are in a wheelchair, do you need help transferring to the dental chair? ☐ yes ☐ no

If you checked boxes in the special needs/disabilities section, are there any accommodations we can make to help your appointment go more smoothly?

_____

_____

If you checked boxes in the special needs/disabilities section, if the patient is 18 or older, does patient have a court appointed guardianship and/or conservator? ☐ yes ☐ no

If yes, name: _____ Phone Number: _____

CONSENT

I, hereby authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Signature: _____

Authorization to Release Information

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

This authorization is valid for one (1) year from the date signed, unless otherwise specified in writing.

Patient first name: _____ Patient Last Name: _____

Patient Signature: _____

Cancellation Policy

We reserve each time especially for our patients and believe that your time is just as valuable as ours. We understand that emergencies may arise that preclude you from keeping your appointment. However, since our office strives to treat patients in a timely manner, we expect the courtesy to be returned. **A minimum of a 24 hour notification must be given to avoid a possible cancellation fee due to the inconvenience caused to the office**. There will be a **$50 charge per hour you are scheduled** for missed/cancelled appointments without a 24 hour notice. After a third missed/cancelled appointment without a 24 hour notice you will need to call to book a same day appointment. If you miss the same day appointment we will no longer be able to see you in the office. Cancellation fees are subject to change.

Tardy Policy

Please give us a call if you will be running late to your appointment. If you are **10 minutes late to an appointment** we will ask our doctor if we can still see you and only get done what we are able to. If the doctor decides we cannot see you we will need to reschedule your appointment for another time. **We reserve each time especially for our patients and believe that your time is just as valuable as ours.**

Signature:_____