Date: ____/____/_____

Patient Information

Name: _____ Preferred Name: _____

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

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: ____ /____ /_____ SS#: _____

Marital Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Mailer	Online Search
Facebook	Work	School	Insurance
Sign –Drive by	Walk in	Other:_____	

Whom may we thank for referring you to our practice?_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

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

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Birth Date: ____ /____ /_____ SS#: _____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

Can we send you appointment reminders via text? Yes No

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Home #: _____ Work #: _____ Mobile #: _____

Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ____ /____ /_____

Insurance Plan Name: _____Insurance Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ____ /____ /_____

Insurance Plan Name: _____Insurance Phone #:_____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Employment Information

Employer Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

Cancellations and Missed Appointments

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice.

I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.

Patient Signature_____Date_____

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____

Physician's Phone#: _____

2. Have you ever been hospitalized (if yes, explain below)? Yes No

_____

3. Have you ever had any excessive bleeding requiring special treatment? Yes No
4. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

5. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Opiate	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

6. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Please list ALL other medications you are taking with dosage and frequency:

_____

_____

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	COPD/Emphysema	Yes No	Glaucoma	Yes No
COVID-19	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS	Yes No
Rheumatic Fever	Yes No	Easy Bruising	Yes No	Hay Fever	Yes No
Hepatitis A/B/C/D	Yes No	Tobacco Products	Yes No	Sickle Cell Disease	Yes No

Sinus Trouble	Yes No	Pacemaker	Yes No	Jaundice	Yes No
Artificial Joints	Yes No	Night Sweats	Yes No	Kidney Trouble	Yes No
Thyroid Disease	Yes No	Stroke	Yes No	Diabetes	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Chemotherapy	Yes No
Blood Transfusion	Yes No	Cold Sores	Yes No	Cancer	Yes No
Mitral Valve Prolapse (MVP)	Yes No	Radiation Therapy	Yes No	Transplant	Yes No

Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____
2. Previous dentist's name / location:_____
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	Yes No	Sensitivity to:	Hot	Cold	Sweets	Biting
Pain in or around your ears	Yes No	Swelling		Bleeding Gums		
Difficulty opening or closing	Yes No	Bad Taste		Bad Breath		
Difficulty chewing	Yes No	Food Catching		Tooth Pain		
History of trauma to jaw or face	Yes No	Clenching		Grinding		
Diagnosis of TMJ/TMD	Yes No	Other: _____				

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date_____

Doctor's Signature_____

Doctor's Notes:

Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. Therefore, we are pleased to offer several payment options. Please read the following carefully. Our financial coordinator will answer any questions you may have and assist you in selecting the appropriate financial plan for your needs.

For your convenience, we offer the following financial options:

1. In addition to personal checks and cash, we also accept payment through MasterCard/Visa, American Express, and Discover. 2. Dental Insurance 3. Smile Club 4. CareCredit

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

- Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.

- Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

- Our participation in a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits within the PPO.

- If your coverage changes for any reason, please notify the office immediately.

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

Usual and Customary Fees

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area and experience. You are responsible for payment regardless of any insurance company's arbitrary determination for usual and customary fees.

I have read the Financial Policy. I understand and agree to this Policy.

_____ _____

Signature of Patient or Responsible Party Date

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____

Signature Date

----------FOR OFFICE USE ONLY----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement ☐ Other (Please Specify)