Patient Information

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Patient Name____Birth Date _____________ SS#______________

Work Phone_______________________ Wireless Phone_____________________Email__________________________

DL #________________________ Gender [ ] M [ ] F Married: [ ] Y [ ] N

If patientis under 18 yrs, please also complete the following:

Guarantor Patient Name_____________________________________Birth Date _____________ SS#______________

Work Phone_______________________ Wireless Phone_____________________Email__________________________

DL #________________________ Gender [ ] M [ ] F Married: [ ] Y [ ] N

Preferred Contact Method [ ] Hm Phone [ ] Wk Phone [ ] Wireless Phone [ ] Email

Student Satus if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Part Time

How did you hear about us? (Please be specific so we can thank them!)___________________________________

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address____

City____ State________________________ Zip____________________

Home Phone__________________________

DENTAL INSURANCE INFORMATION (Primary Carrier)	If you have a double digit insurance coverage, complete this for the second coverage
Insured's name DOB SS#	Insured's name DOB SS#
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone #	Phone #
Group # Local #	Group # Local #

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. For my convenience, this office may release information to my insurance and receive payments directly from them.

- **If sent to collection, I agree to pay $30 collection fee and all related fees and court costs.**
- **Treatment plans and clinical circumstances may change. I will be financially responsible for the actual treatment completed.**
- **I acknowledge that I will be charge a <u>$25 cancellation fee</u> if cancelling an appointment with less than 24 hrs notice.**
- **Please Note: Returned checks will be subject to additional fees**

We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

Do You Have Insurance?

- 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 ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. 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. Our office is not a party to that contract.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. 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 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 questions you may have concerning your care or our financial policy.

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 HAVE READ, UNDERSTAND AND AGREE THE NOTICE OF PRIVACY PRACTICES AND ALSO THAT I CAN RECEIVE A PAPER COPY UPON REQUEST

PATIENT Signature (Parent of Child)____Date:_______________

Medical History

Name of Medical Doctor:___________________________ Doctor City/State________________________

Emergency Contact:_________________________ Emergency Phone Number__________________

List Medications You Are Now Taking:

Check Which Of The Following You Are Allergic To:

☐	None	☐	Metals
☐	Aspirin	☐	Anesthetics
☐	Codein/Narcotics	☐	Penicillin
☐	Aspirin	☐	Sulf Drugs

Other: ____

Check Any Medical Conditions You Have Had:

☐	None	☐	Pacemaker	☐	Heart Attack/ Stroke	☐	Mitral Valve Prolapse
☐	AIDS/HIV	☐	Chest Pain	☐	Heart Disease/ Angina	☐	Persistent Diarrhea
☐	Alcohol/ Drug Abuse	☐	Damaged Heart Valve	☐	Heart Murmer	☐	Rheumatic Fever
☐	Anemia/Leukemia	☐	Diabetes	☐	Hepatitis/ Jaundice	☐	Sexually Transmitted Disease
☐	Anorexia / Bulimia	☐	Emphysema	☐	High Blood Pressure	☐	Sinus Trouble
☐	Arthritis	☐	Epilepsy	☐	Hives/ Skin Rash	☐	Stomach Ulcers
☐	Asthma / Hay Fever	☐	Fainting/ Seizures	☐	Joint Replacement	☐	Thyroid Problems
☐	Blood Clot Problems	☐	Fever Blisters/Herpes	☐	Kidney/ Bladder Trouble	☐	Tuberculosis
☐	Blood Transfusion	☐	Frequent Headaches	☐	Liver Disease		
☐	Bronchitis	☐	Dry Mouth/ Sjogren	☐	Low Blood Pressure		
☐	Cancer/ Tumor	☐	Gall Bladdes Trouble	☐	Mental Health Problems		

Other:____

Do you use tobacco? If so, what kind and how much?____

Do you have any unusual reactions to dental injections?____

Are you Pregnant or have any reason to believe you may be? ☐ Yes ☐ No

Do you take vitamin supplements?	☐ Yes	☐ No		Do you take any weight loss supplements?	☐ Yes	☐ No
Do you purchase primarily organic foods?	☐ Yes	☐ No		Do you take work out supplements?	☐ Yes	☐ No
Do you take health replacement shakes?	☐ Yes	☐ No		Do you drink energy drinks?	☐ Yes	☐ No

Do you wish your smile was prettier?	☐ Yes	☐ No		Do you have any missing teeth	☐ Yes	☐ No
Do you have crooked teeth?	☐ Yes	☐ No		Do you have any dental pain	☐ Yes	☐ No

Reason for today' visit:

By signing below I certify that all of the above information is true to the best of my knowledge

_______________________________ _______________________________ _______________

Name of Patient/ Guardian (printed) Signature Date