

## Patient Information

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Marital Status (circle one):    Single    Married    Divorced    Widowed    Separated

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Driver's License/State ID #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_

Spouse/Parent's Employer: \_\_\_\_\_

Spouse/Parent's Employer Address: \_\_\_\_\_

Spouse/Parent's Work Phone: \_\_\_\_\_

Whom shall we contact in case of emergency? \_\_\_\_\_

Phone number they can be reached at: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_



### A Note to Our Patients:

*Thank you for trusting us with your dental care.*

*We promise to do our best to provide you with*

*the finest care available. If you have any*

*questions, please don't hesitate to call us.*

## Dental History

Reason for today's visit: \_\_\_\_\_

Former Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Check the box if you have any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to heat or cold    |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to Sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Snoring                        | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Are you happy with the appearance of your smile?                      Yes      No

## Medical History

Physician's name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Have you had any serious illness or operations?                      Yes      No

If Yes, Describe: \_\_\_\_\_

Have you ever had a blood transfusion?                      Yes      No

If Yes, give approximate dates: \_\_\_\_\_

(Women Only) Are you pregnant?                      Yes      No

   Nursing?                      Yes      No

   Taking birth control pills?                      Yes      No

Check the box if you have any of the following:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever           |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath     |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Sleep Apnea             |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of feet/ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems        |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis             |
| <input type="checkbox"/> Chem. Dependency        | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                   |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Describe             | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease        |

**Medications/Allergies**

List any known allergies/allergic reactions:

---

---

---

List any medications you are currently taking:

---

---

---

**Authorization and Release**

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(If patient is a minor, parent/guardian should sign)*

Payment is due in full at time of treatment unless prior arrangements have been approved.

## **Financial Options**

Our commitment is to provide quality dental care for the entire family through our exceptional service and application of advanced technology.

### Methods of Payment (No Checks Accepted)

1. Cash or Credit Card (Visa, MasterCard, American Express, and Discover)
2. Care Credit or Dental Fee Plans (3<sup>rd</sup> Party)
3. Debit or Check Card

### Dental Insurance (If Applicable)

1. We are pleased you have dental insurance and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company.
2. As a courtesy to you, we will file your insurance if we are able and we will accept assignment of benefits. We ask that your estimated co-payment and deductible be paid at the time of service.
3. Not all services are a covered benefit in all contracts. Some companies arbitrarily select certain services they will not cover.
4. For any major work (Bridges, Crowns, Partials, Dentures, etc.) most insurance companies do not require a pre-determination. However, as a courtesy to our patients, we submit pre-determinations so that the patient is aware of the amount the insurance will pay. This process takes 4-6 weeks. If the work needs to be done right away, we will ask you to take care of the payment in full and the insurance company will reimburse you directly.

## **Related Information**

Your appointment time has been reserved exclusively for you. Any changes in your appointment may affect other patients. 24 hours notice is required to avoid a broken appointment charge of \$75.00 (all appointments over 1 hour may incur additional costs).

I have read and understood the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from services rendered.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Acknowledgement of Receipt of Notice of Privacy Practices**

*You may refuse to sign this acknowledgement*

I, \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

Please Print Name: \_\_\_\_\_

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
- Communications barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)