Patient Information

Patient Name:_____
Last First MI (Preferred Name)

Gender_____ Family Status: _____ Phone (Cell)_____ SSN _____

Birth Date:_____ Email: _____

Address:_____
Street Apartment

_____
City State Zip Code

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number:_____

Preferred Pharmacy (Name)_____ (Street Name)_____

Health Information

Have you ever had any of the following? Please check those that apply:

__AIDS/ HIV
__Anemia
__Arthritis
__Artificial Joints
__Asthma
__Blood Disease/ Transfusion
__Cancer
__Codeine Allergy
__Diabetes
__Dizziness
__Epilepsy
__Excessive Bleeding
__Fainting
__Glaucoma
__Growths
__Hay Fever
__Head Injuries
__Heart Disease
__Heart Murmur
__Hepatitis
__High Blood Pressure
__Jaundice
__Joint. Valve Replacement(s)
__Kidney Disease
__Latex Allergy
__Liver Disease
__Mental Disorder
__MVP
__Nervous Disorders
__Pacemaker
__Penicillin Allergy
__Radiation Treatment
__Respiratory Problems
__Rheumatic Fever
__Rheumatism
__Sexually Transmitted Diseases
__Sinus Problems
__Stomach Problems
__Stroke
__Tuberculosis
__Tumors
__Ulcers

• Do you take: Fosamax_____ Aspirin Therapy _____ Blood Thinners_____

• Have you ever had any complications following dental treatment? Do you suffer from TMD? ☐ Yes ☐ No

If yes, please explain: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

• Please list any medications that you are currently taking: _____

_____

_____

Dental Information

Reason for today's dental visit: _____

What was done on your last dental visit? _____ Date of Last Dental Visit: _____

How frequently do you brush your teeth?

3(+) a day Twice a day Once a day Weekly Seldom

How frequently do you floss your teeth?

1(+) a day 2-6 weekly 1-6 monthly Seldom Never

Please check any of the following to indicate "Yes" in response to the question:

- € Do your gums bleed when you brush or floss?
- € Do your teeth experience sensitivity to cold or hot temperatures?
- € Are any of your teeth currently causing you pain?
- € Do you grind your teeth (either consciously or during sleep)?
- € Are any of your teeth loose, or are you concerned about any teeth loosening?
- € Do you currently have any dental implants, dentures, or partials?
- € Do you suffer from dental anxiety?
- € Have you ever had any complications following dental treatment?

If any of the previous questions are marked, please explain:

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be? (i.e. straighter/ whiter teeth, less wrinkles, TMD, etc)

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?

- € Another patient
- € Work
- € School
- € Yelp!
- € Internet Search Engine
- € Insurance Company
- € Other: _____

Name of person or office referring you to our practice: _____

Consent for Services:

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

If you are covered by one of our accepted plans and can provide a valid insurance card or other evidence of coverage we will bill your insurance. **You are responsible for all charges for services you receive.**

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services not reimbursed by insurance. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will apply any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination. I also understand that, for patients with insurance, the fees are determined by the dental insurance carrier and are subject to change.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Office Policies:

When our office books your appointment, we are reserving chair time specifically for you. Please be on time so that the scheduled treatment can take place. If you need to reschedule your appointment, we ask that you please provide us with 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient.

Patients without insurance are expected to pay in full the day the services are rendered, unless specific arrangements are made in advance. We accept all major credit cards, cash, Care Credit, and personal checks.

For patients covered by insurance, we will accept assignment of benefits; however, your coinsurance, copay, and/ or any outstanding deductibles will be due the day services are rendered. We will estimate your total as closely as possible, but the ultimate responsibility lies with you. Any unpaid balance over 90 days will be sent to an attorney for collections. Any attorney fee(s) will be the responsibility of the patient/ parent/ legal guardian.

Notice of Privacy Practices:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy. These policies are attached to this clipboard and we ask that you please review the policies carefully.

I have read through the Office Policies, Notice of Privacy Policy, and Consent for Services.

_____

Patient's Name (Print)

_____

Patient's Signature Date