

# Welcome!

To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please ask someone at the front desk and we will be happy to help you. Thanks for being our patient!

## Patient Information

Name \_\_\_\_\_  
Last First MI

Preferred Name \_\_\_\_\_ Title \_\_\_\_\_

Male  Female  Child  Single  Married  Other

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Driver's Lic \_\_\_\_\_ State \_\_\_\_\_  
(photocopy required)

Address \_\_\_\_\_

City State Zip Code

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Wk Phone \_\_\_\_\_

Emergency Contact Name/Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## Insurance Information

Insured Employee \_\_\_\_\_

Insured's SSN \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Relationship to Patient \_\_\_\_\_

College (full-time students only) \_\_\_\_\_

### Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

**X** \_\_\_\_\_  
Responsible Party Signature

Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

## Office & Financial Policies

At least 48 hours is required for appointment changes or cancellations. Appointments cancelled with less than 48 hours notice incur a \$25 charge; an additional \$25 fee is charged for appointments with specialists.

Valid identification is required for all personal checks. Returned checks will be subject to the terms and conditions of the electronic check acceptance company used in this office, including any fees charged by that company.

Payment and/or Co-payment is required in full at the time services are rendered. In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that Medical/Dental Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned understands that the co-payment requested for services is only an ESTIMATE of what the insurance will not cover based upon information provided by the insurance company and NOT A GUARANTEE OF PAYMENT. The actual insurance benefit may differ from our estimates. **I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY UNPAID BALANCE.**

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I : { } **am** { } **am not** an active duty member of the U. S. Armed Forces.

**I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.**

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Over Please...

# Dental Health History

Name: \_\_\_\_\_

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

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

Phone \_\_\_\_\_

Date of last dental exam \_\_\_\_\_

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

Date of last cleaning \_\_\_\_\_

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

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

Do you feel pain anywhere? \_\_\_\_\_

Describe \_\_\_\_\_  
 \_\_\_\_\_

**Circle "Yes" or "No" to indicate whether you have had any of the following conditions:**

Sensitivity to hot or cold Yes No  
 Sensitivity to sweet Yes No

Avoid one side of the mouth when chewing Yes No  
 Sensitivity when biting Yes No

Broken / cracked fillings Yes No  
 Food collection between teeth Yes No

Tobacco use Yes No

Gums swollen or tender Yes No  
 Gums bleed frequently Yes No

Blisters on lips or mouth Yes No  
 Sores or growths inside cheek / in the mouth Yes No

Bad breath Yes No  
 Burning sensation on tongue Yes No  
 Dry mouth Yes No

Accident involving jaw Yes No

Clicking or popping jaw Yes No  
 Frequent headaches Yes No  
 Grinding teeth Yes No  
 Jaw pain or tiredness Yes No  
 Pain around ear Yes No

Orthodontic treatment Yes No  
 Periodontal treatment Yes No

# Medical Health History

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Please list all current medications (include prescription, over-the-counter, herbal supplements) and reason for use:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Are you allergic to any of the following?**

Aspirin  Codeine  Latex  Penicillin  Valium

Other: \_\_\_\_\_

**Have you ever had any of the following conditions?**

Artificial joint/valve  Heart murmur  Mitral valve prolapse  Rheumatic fever

**Women Only:**

Do you use birth control medication? Yes No  
 Are you nursing? Yes No  
 Are you pregnant? (Due date: \_\_\_\_\_) Yes No

**Circle "Yes" or "No" to indicate whether you have had any of the following conditions:**

AIDS / HIV Yes No  
 Anemia Yes No  
 Arthritis or Back problems Yes No  
 Asthma or Respiratory problems Yes No  
 Blood transfusion (Date: \_\_\_\_\_) Yes No  
 Cancer Yes No  
 Cardiac pacemaker Yes No  
 Convulsions / Epilepsy / Seizures Yes No  
 Diabetes Yes No  
 Excessive bleeding with surgery / extractions Yes No  
 Heart problems Yes No  
 Hepatitis or Liver problems Yes No  
 High or Low blood pressure Yes No  
 Kidney problems Yes No  
 Phen-Phen treatment Yes No  
 Radiation or Chemotherapy treatment Yes No  
 Sexually transmitted disease Yes No  
 Stroke Yes No  
 Thyroid disorder Yes No  
 Tuberculosis Yes No

**Other:** \_\_\_\_\_

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

Responsible Party Signature \_\_\_\_\_

\_\_\_\_\_ Date

Attending Dentist Signature \_\_\_\_\_

\_\_\_\_\_ Date