PATIENT INFORMATION:

__Mr. __Mrs. __Ms. __Dr.
First Name:_____M.I._____Last Name:_____
Sex: __M __F DOB:_____Age:_____SSN:_____
Street:_____Apt:_____City:_____State:_____Zip:_____
Home #:_____Cell #:_____
Orthodontist:_____Medical Dr:_____
Employer:_____Email:_____
In case of emergency, please contact:_____Telephone:_____Relation:_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:
Name:_____SSN:_____DOB:_____
Street:_____Apt:____City:_____State:____Zip:_____
Employer:_____Telephone:_____
Email:_____

SPOUSE OR OTHER GUARANTOR INFORMATION:
Name:_____Relation:_____SSN:_____
DOB:_____
Street:_____Apt:____City:_____State:___Zip:_____

PRIMARY DENTAL INSURANCE INFORMATION:
Employer:_____Insurance Company Name:_____
Address:_____Telephone#:_____
Group Name:_____Group #:_____
Policyholder:_____Relation:_____
DOB:_____SSN:_____

SECONDARY DENTAL INSURANCE INFORMATION:
Employer:_____Insurance Company Name:_____
Address:_____Telephone#:_____
Group Name:_____Group #:_____
Policyholder:_____Relation:_____
DOB:_____SSN:_____

PLEASE RETURN THIS SHEET TO THE FRONT DESK BEFORE PROCEEDING

NEXT PAGE

How would you like your appointment confirmed? Txt E-mail Phone

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff responsible for any errors or emissions that I have made in the completion of this form.

Signature of Patient (Parent or Guardian if Minor) Date

REFERRAL INFORMATION

Whom may we thank for referring you to our practice_____,friend/relative/co-worker

FEES & PAYMENTS

We make every effort to keep down the cost of your care. We are committed to providing you with the best possible care and will gladly answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. Assisting in the filing of insurance claims is a courtesy that we extend to our patients; all charges are your responsibility from the date the services are rendered.

Payment for services is due at the time services are rendered. We will be happy to submit claims to your insurance for payment; however you are responsible for any unpaid balances.

Signature of Patient (Parent or Guardian if Minor) Date

This signature on file is my authorization for release of information necessary to process my claim. I hereby authorize payment to the doctor named of the benefits otherwise payable to me.

Signature of Patient (Parent or Guardian if Minor) Date

AUTHORIZATION

I authorize my doctor and his/her designated staff, to perform an dental examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of my examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

Signature of Patient (Parent or Guardian if Minor) Date

MISSED APPOINTMENT POLICY

Broken appointments are a loss to everyone. If unable to keep your appointment, please give 24 hours' notice or there will be a **$50.00 missed appointment fee.** (Not billable to insurance).

Signature of Patient (Parent or Guardian if Minor)

PHOTOS

Photos are used for communication within our office, lab use, and educational purposes only.

Signature of Patient (Parent or Guardian if Minor)

DENTAL & HEALTH INFORMATION

Date of Last Dental Visit:_____ Reason for Today's visit:_____

- Have you ever had any complications with dental treatment? ▫ Yes ▫ No
- If yes, please explain:_____
- What is your oral health goal?_____
- Have you ever been told you have periodontal (gum) disease? ▫ Yes ▫ No Dental Cavities? ▫ Yes ▫ No

What would you like to change about your smile?

_____
_____
_____

Do you currently have or ever had any of the following? Please check those that apply:

▫ AIDS
▫ Arthritis
▫ Artificial Joints
▫ Asthma
Inhaler used____
▫ Blood Concerns (i.e. Anemia, excessive bleeding, Bruising)
▫ Cancer
▫ Diabetes
▫ Depression or Anxiety
▫ Dizziness/Fainting
▫ Epilepsy/Seizures
▫ Glaucoma
▫ Growths
▫ Head Injuries/Concussion
▫ Heart Disease
▫ Heart Murmur
▫ Hepatitis A,B, or C
▫ Herpetic lesions (i.e. cold sores, apthous ulcers, oral)
▫ High or Low Blood Pressure
▫ Kidney Problems
▫ Liver Disorders
▫ Osteoporosis
Which medication(s)?
_____
▫ Pacemaker yr placed ____
▫ Pregnancy
Due date:_____
▫ Radiation or Chemotherapy Treatment
▫ Respiratory Problems (i.e. COPD, pneumonia, bronchitis, other)
▫ Rheumatism
▫ Sinus Problems or Seasonal Allergies
▫ Stomach Problems
▫ Smoking or tobacco
▫ Stroke or TIAs
▫ Thyroid Disorder
▫ Tuberculosis
▫ Blood thinning medication, including Aspirin
▫ Epinephrine Reaction
▫ Codeine Allergy
▫ Penicillin Allergy
▫ LATEX Allergy
▫ Medication allergies not listed:_____
▫ Other condition not listed

Have you or Are you currently taking the following?
▫ Bisphosphonate
▫ Pre-Medication for (antibiotic) dental visits

▫Family history of Diabetes, High blood pressure, Disease, Stoke

- Please list **ALL** medications, herb, or supplements you are currently taking:_____
  _____
- Have you been admitted to a hospital, needed emergency care, or surgery within the past two years? ▫Yes ▫No
  If yes, please explain:_____
- Are you now under the care of a physician? ▫ Yes ▫ No Name of Physician:_____ Phone:_____
  If yes, please explain:_____
- Any other diseases, illnesses, surgeries, disabilities, or above conditions that need further clarification? ▫ Yes ▫ No
  If yes, please explain:_____

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 or medications, I will inform the office at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date