Today's Date_____/_____/_____

Patient Information

Name_____ Birthdate_____/_____/_____

Address_____ Apt#_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Work Phone_____ Other Phone_____

Email_____ Social Security No_____-_____-_____

Who May We Thank For Referring You_____

Emergency Contact and Phone Number_____

Mark Appropriate Space ___Minor ____Single ___Married ___Divorced ____Widowed

Patient or Parents Employer_____

Occupation/Position_____

City, State, Zip Code_____

Working Days/Hours _____

Responsible Party

Name of Person Responsible for this Account_____

Relationship to Patient_____

Address_____ Apt#_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Driver's License_____ Social Security No_____-_____-_____

Today's Date_____/_____/_____

Insurance Information

Primary Insurance Company_____

Insurance Company Address_____

City_____ State_____ Zip Code_____

Group Number_____ Policy/ID Number_____

Insurance Phone No_____

Name of Employer_____

Address of Employer_____

City_____ State_____ Zip Code_____

****

Secondary Insurance Company_____

Insurance Company Address_____

City_____ State_____ Zip Code_____

Group Number_____ Policy/ID Number_____

Insurance Phone No_____

Name of Employer_____

Address of Employer_____

City_____ State_____ Zip Code_____

Medical History (Confidential)

Today's Date_____/_____/_____

Physician's Name_____ Date of Last Exam_____

Office Phone Number_____

1. Are you currently undergoing medical treatment? Y/N
2. Have you had a surgery or been hospitalized in the past 5 years? Y/N
   If yes, please explain:_____
3. Do you smoke tobacco? Y/N
4. Do you drink alcohol? Y/N
5. Do you/have you used any controlled substances? Y/N
6. Have you ever taken Fosamax, Boniva, Actonel or any other Bisphosphonate medication to treat cancer and/or osteoporosis? Y/N
7. Have you taken Viagra, Cialis, Levitra, Revati in past 24 hours? Y/N
8. Are you currently taking any medications? Y/N

   Please list all medications, strength of dosage, frequency below:

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

9. Are you allergic to any of the following? Please Circle All That Apply

   Local Anesthesia (ex: Novocain)
   Antibiotics (ex: Penicillin)
   Sulfa Drugs
   Barbiturates
   Sedatives
   Iodine/Shellfish
   Aspirin
   NSAIDS (ex: Advil, Motrin, Ibuprofen, Alleve)
   Any Metals (ex: Nickel, Mercury, Silver)
   Latex
   Other_____

10. Do you or have you ever had any of the following: Please Circle All That Apply

Today's Date_____/_____/_____

Coronary/Heart Disease	Diabetes	Kidney Disease
High Blood Pressure	Cancer	Epilepsy/Seizures
Low Blood Pressure	Radiation Therapy	Leukemia
Heart Attack	Chemotherapy	Joint Replacement
Heart Murmur	Stomach Problems	Thyroid Problems
Mitral Valve Prolapse	Gastric Reflux	Anemia
Chest Pains/Angina	Liver Disease	Fainting
Stroke	Hepatitis/Jaundice	Arthritis
Swollen Ankles	Respiratory Disease	HIV/AIDS
Pacemaker	Asthma	STD
Rheumatic Fever	Tuberculosis	Recent Weight Loss
Eye Disease	Seasonal Allergies	Other_____

NONE

Past Dental Experiences

Is there anything in particular that you did not like about your previous dentist?

_____

Is there anything our office can do to make your dental experience more pleasant?

Dental History

Name of Previous Dentist_____

Date of Last Exam/Cleaning_____

Today's Date_____/_____/_____

1. Do your gums bleed while brushing or flossing? Y/N
2. Are your teeth sensitive to hot or cold food or liquids? Y/N
3. Are your teeth sensitive to sweets? Y/N
4. Do you feel any pain in your teeth? Y/N
5. Do you have any sores or lumps in your mouth? Y/N
6. Have you had any difficult extractions in the past? Y/N
7. Do you bite your lips or cheeks frequently? Y/N
8. Have you had orthodontic treatment (braces) in the past? Y/N
9. Do you wear partial or complete dentures? Y/N
10. Have you ever experienced any jaw problems? Y/N
    a. Do you grind your teeth ? Y/N
    b. Do you get headaches/migraines frequently? Y/N
    c. Do you have any clicking or popping of your jaw? Y/N
    d. Were you ever hit in the jaw? Y/N
    e. Do you ever feel pain in the jaw? Y/N
    f. Do you ever have limited opening of the jaw? Y/N
    g. Have you ever had your jaw locked in place? Y/N

Dental Goals

I would like to: Please Circle All That Apply

Whiten My Teeth	Straighten My Teeth	Change Metal Fillings
Improve My Smile	Improve My Dental Health	Better Fitting Dentures
Replace Missing Teeth	Stop My Gums from Bleeding	Treat Headaches/Migraines
Receive Dental Education	Get Rid of My Fear of the Dentist	Better Breath

Nothing: I Love My Teeth

Signature of Patient/Parent_____

Financial Policy

Our office is committed to providing you with the best dental care possible. If you have dental insurance, we are more than happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our office policy.

Today's Date_____/_____/_____

Our office tries to keep our fees at a lower cost by working efficiently. You can help us do this by paying your accounts in a timely manner. This will reduce our operating cost and we can therefore pass our savings towards our patients.

Our office accepts various methods of payment: cash, credit cards, checks, and Care Credit.

Insurance:

We will be happy to help you process your insurance claims for reimbursement. However, we must emphasize that as a dental care provider, our relationship is with the patient, not the insurance company. Your insurance is a contract between the insurance company, your employer, and the patient. Our fees are generally considered to fall within the acceptable range for most offices in this area. Lastly, not all services are a covered benefit in all contracts. Some insurance companies elect not to cover some procedures. While the filing of insurance claims on behalf of the patient is a courtesy, all charges are ultimately the responsibility of the patient from the dates the service is rendered.

Discounts:

A 5% or higher discount will be given to patients without insurance who keep their appointments as scheduled (excluding orthodontics).

For patients with insurance, our office is willing to give a courtesy towards their out of pocket expenses if the doctor is an out-of-network provider. Unfortunately, if our doctor is an in-network provider, he is contractually obligated to charge the patient their responsibility usually at a lower fee.

We realize that financial problems may arise that can affect your payment in a timely manner. If such problems do occur, we encourage you to contact us promptly to assist you in managing your account. If you have any questions about our policy or your account, please do not hesitate to ask. We are here to help you in every way.

I HAVE READ AND UNDERSTOOD THE FINANCIAL POLICY

Signature_____