



Date: _____ How did you hear about us? _____

Last Name: _____ First Name: _____ Middle Int: _____

Preferred Name: _____

Address: _____ City, State and Zip: _____

Cell phone: _____ Home Phone: _____ Work Phone: _____

Sex: Male _____ Female _____ Marital Status: Married _____ Single _____ Other _____

Birth Date: _____ Social Security Number: _____

E-mail Address: _____

What is the best way to reach you: Cell Phone (Call) _____ Text Msg _____ Email _____

What is the reason for today's visit to the dentist?

When were you last seen by a dentist? _____

What was done during the last visit? _____

Employment History:

Employment Status: FT _____ PT _____ Retired _____ Occupation: _____

Employer: _____

Are you a Student? FT _____ PT _____ Name of School: _____

Is the patient the responsible party? YES ___ NO___

Responsible Party (if patient is responsible party, do not fill out this section)

Name: _____ Date of Birth: _____

Address: _____ City, State and Zip: _____

Cell phone: _____ Home Phone: _____ Work Phone: _____

Social security number: _____ Relation to patient: _____

Primary Insurance:

Name of Insured: _____ Date of Birth: _____
Address: _____ City, State and Zip: _____
Cell phone _____ Home Phone: _____ Work Phone _____
Insured social security number: _____ Relation to patient: _____
Employer: _____ ID number: _____ Group # _____
Insurance Company: _____ Address: _____

Secondary Insurance:

Name of Insured: _____ Date of Birth: _____
Address: _____ City, State and Zip: _____
Cell phone _____ Home Phone: _____ Work Phone _____
Insured social security number: _____ Relation to patient: _____
Employer: _____ ID number: _____ Group # _____
Insurance Company: _____ Address: _____

Insurance & Financial Policy

ACKNOWLEDGEMENT AND RELEASE

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however the dentist’s treatment recommendations are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company.

In an effort to provide our patients with dental insurance support, we will:

- 1. Do our best to verify insurance benefits**
- 2. Provide an “ESTIMATE” of your co-payment**
- 3. Submit your insurance claims and assist you with maximizing insurance benefits**

*******ESTIMATED FEES ARE DUE AT THE TIME OF SERVICE. The estimate is based on your insurance benefits, however, each policy is subject to limitations and/or exclusions that we may not be aware of. We encourage you to contact your insurance company if you have questions or concerns regarding your coverage.**

ALL FEES NOT PAID BY INSURANCE ARE YOUR RESPONSIBILITY.

SIGNATURE _____ Date _____

Cancellation Policy

RESTORATIVE AND HYGIENE APPOINTMENTS

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people --- the patient who missed the valuable time, the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

We ask for at least 48 hours advance notice for canceling or rescheduling an appointment; otherwise, a \$50 fee may be assessed to your account.

Note: All cancellation fees must be paid prior to scheduling another appointment.

SIGNATURE _____

Date _____

Oral Health

Do you have existing pain in your mouth Yes ___ No ___ Location: _____

Do you have pain when eating? Yes ___ No ___

Do you have sensitivity to hot and cold? Yes ___ No ___

Do you have pain during the day? Yes ___ No ___

Do you have pain that wakes you up in the middle of the night? Yes ___ No ___

Is there is anything that you don't like about your teeth? _____

How happy are you with your smile (on a scale of 1-10)? _____

Have you ever been treated for periodontal (gum) disease? Yes ___ No ___

Please check any conditions that apply to you below:

Pain In Jaw (TMJ) ___ Teeth Grinding/Clenching ___ Use Tobacco Products ___

Mouth Sores ___ Sensitive Teeth ___ Broken/Loose Teeth ___

Difficulty Chewing/Swallowing ___ Swollen/Bleeding Gums ___

Have you ever had teeth extracted Yes ___ No ___ If yes, how many? When? ____/____/____

For what reason? _____

Are you currently wearing Dentures? Yes ___ No ___

Age of dentures: Less Than 6 Months ___ 6 months ___ 3 years ___ Greater than 4 years ___

Have you ever had Novocaine or other local anesthetic? Yes ___ No ___

Have you ever had an allergic reaction to local anesthetics? Yes ___ No ___

Does dental treatment make you nervous? Not at all ___ Slightly ___ Moderately ___ Extremely ___

Have you ever had orthodontic treatment (braces)? Yes ___ No ___

Do you have a splint, mouthguard or a nightguard? Yes ___ No ___ If yes, which one ___

How long have you worn one? How often? _____

Medical History

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

- | | | |
|---|----------------------------|----------------------------|
| *AIDS _____ | *Epilepsy _____ | *Mental Disorder _____ |
| *Anemia _____ | *Excessive bleeding _____ | *Nervous Disorder _____ |
| *Arthritis _____ | *Fainting _____ | *Pacemaker _____ |
| *Artificial joint _____
/Replacement | *Head Injuries _____ | *Radiation Treatment _____ |
| *Asthma _____ | *Hepatitis _____ | *Respiratory Problem _____ |
| *Blood Disease _____ | *High Blood Pressure _____ | *Sinus Problem _____ |
| *Cancer _____ | *Kidney Disease _____ | *Stomach Problem _____ |
| *Diabetes _____ | *Latex Allergy _____ | *Stroke _____ |
| *Dizziness _____ | *Liver Disease _____ | *Tuberculosis _____ |
| *Osteoporosis _____ | *Sleep Apnea _____ | *Snoring _____ |

Do you have any drug allergies? _____

For Women: Are you pregnant? _____

Are you under the care of a physician? _____ Date of the last physical examination: _____

Name and phone # of family physician _____

Have you ever had any serious illness or operation? ___ Yes ___ No. If yes, describe: _____

Have you ever been hospitalized? ___ Yes ___ No. If yes, describe: _____

Do you smoke? ___ Yes ___ No - If yes, what & how much? _____ Cigars _____ Cigarettes Packs per day = _____

Are you using any recreational drugs? ___ Yes ___ No. If yes, what? _____

Do you have any health issues that we should be aware of? _____

Preferred Pharmacy: _____

Please list any medications that you are currently taking:
