PATIENT INFORMATION

Name_____ Preferred Name _____ Birthday_____

Address_____ City_____ State_____ Zip_____

Employer_____ SS# _____ Spouse/Parent's Name_____

Home Phone_____ Work_____ Cell_____

E-mail Address _____

Person to Contact in Case of Emergency_____ Phone_____

Check appropriate box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Student

Whom may we thank for referring you? _____

MISSED APPOINTMENTS

We expect patients to be present at all scheduled appointments. **If the need does arise to cancel, *at least 24 hours* advance notice is necessary** to allow other patients to make necessary arrangements, or a fee may be applied. Thank you.

If you are more than 10 minutes late, we may need to reschedule your appointment _____

Please sign

DENTAL INSURANCE INFORMATION

Name of Insured_____ Relation to Patient_____

Birthdate _____ Social Security #_____ Date Employed_____

Employer _____ Work Phone_____

If Dental Insurance card not available, you must provide the following information:

Insurance Company_____ Group #_____ ID #_____

Address _____ City_____

State _____ Zip_____ Phone(s)_____

DENTAL HISTORY

Reason for Today's Visit_____

Former Dentist_____

Date of Last Dental Visit_____ Date of Last Dental X-rays_____

Check (❒) if you have had any of the following:

❒ Bad Breath
❒ Bleeding Gums
❒ Clicking or Popping Jaws
❒ Food Collection Between Teeth
❒ Grinding Teeth
❒ Loose Teeth or Broken Fillings
❒ Periodontal Treatment
❒ Sensitivity to Cold
❒ Sensitivity to Heat
❒ Sensitivity to Sweets
❒ Sensitivity When Biting
❒ Sores or Growths in Your Mouth

Over Please

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit_____

Have you ever had a blood transfusion ❒ Yes ❒ No If yes, give approximate dates_____

(Women) Are you pregnant? ❒ Yes ❒ No Nursing? ❒ Yes ❒ No Taking Birth Control Pills ❒ Yes ❒ No

Check (❒) if you have had any of the following:

❒ AIDS
❒ Anemia
❒ Arthritis, Rheumatism
❒ Artificial Heart Valves
❒ Artificial Joints
❒ Asthma
❒ Back Problems
❒ Blood Disease
❒ Cancer
❒ Chemotherapy
❒ Circulatory Problems
❒ Cortisone Treatments
❒ Cough, Persistent
❒ Cough up Blood
❒ Diabetes
❒ Epilepsy
❒ Fainting
❒ Glaucoma
❒ Headaches
❒ Heart Problems
Describe_____
❒ Hemophilia
❒ Hepatitis
❒ High Blood Pressure
❒ HIV Positive
❒ Jaw Pain
❒ Kidney Disease
❒ Liver Disease
❒ Mitral Valve Prolapse
❒ Osteoporosis
Medication? _____
❒ Psychiatric Care
❒ Radiation Treatment
❒ Respiratory Disease
❒ Rheumatic Fever
❒ Scarlet Fever
❒ Shortness of Breath
❒ Skin Rash
❒ Stroke
❒ Swelling of Feet or Ankles
❒ Thyroid Problems
❒ Tobacco Habit
❒ Tuberculosis
❒ Ulcer
❒ Venereal Disease

List medications you are currently taking:_____

List any Surgeries or major illnesses:_____

List Allergies you have:_____

Do you have any known metal allergies? ❒ Yes ❒ No

FINANCIAL / INSURANCE POLICY

We accept cash, checks or credit cards.

Your insurance policy is a contract between you, your employer and the insurance company. We are committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Not all services are a covered benefit in all contracts. Your employer and insurance company may arbitrarily select certain services that they will not cover.

As a courtesy service for our insured patients we do file your insurance claim for you. A minimum payment of 20% is required at the time of treatment (excluding preventative care i.e. cleanings). Regardless of what your insurance company determines your benefits are, it is not a guarantee of payment. All charges are your responsibility from the date of services rendered.

After your appointment we will file your insurance claim for you. Therefore, it is very important that we are given your correct and current dental *insurance*. If we do not receive insurance payment within 30 days, we will re-file your claim for you. After 60 days from the date of service, if the balance has not been paid, we will ask you to pay your balance in full; including any unpaid insurance claims. *You* can then ask the insurance company to send reimbursement directly to you for that claim.

In the event of default, meaning full payment has not been received within 90 days after treatment; the patient agrees to pay all costs including those incurred from a collection agency. This includes any and all collection agency fees, reasonable attorney fees, whether or not legal proceedings are commenced, and all court costs. Furthermore, in the event of default, interest shall accrue at the rate of 18% per annum.

I authorize and request 1.) my insurance company to pay directly to the dentist insurance benefits 2.) the doctor to release all information necessary to secure the payment of benefits 3.) the use of this signature on all insurance submissions.

I have read and answered the above medical history and financial insurance policy to the best of my knowledge.

_____ Signature _____ Date

_____ Signature _____ Date

_____ Signature _____ Date

_____ Signature _____ Date

_____ Signature _____ Date

_____ Signature _____ Date

_____ Signature _____ Date

_____ Signature _____ Date