PATIENT INFORMATION

CONFIDENTIAL

PATIENT SS# _____

DATE _____

(PLEASE PRINT)

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

SIGNATURE

X _____

SIGNATURE OF PATIENT OR PARENT IF MINOR

HEALTH HISTORY

Patient Name:_____ Soc. Sec. No.:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes ○ No ○ Is your general health good?
2. Yes ○ No ○ Has there been a change in your health within the last year?
3. Yes ○ No ○ Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes ○ No ○ Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam_____
5. Yes ○ No ○ Have you had problems with prior dental treatment?
6. Yes ○ No ○ Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes ○ No ○ Chest pain (angina)?
8. Yes ○ No ○ Swollen ankles?
9. Yes ○ No ○ Shortness of breath?
10. Yes ○ No ○ Recent weight loss, fever, night sweats?
11. Yes ○ No ○ Persistent cough, coughing up blood?
12. Yes ○ No ○ Bleeding problems, bruising easily?
13. Yes ○ No ○ Sinus problems?
14. Yes ○ No ○ Difficulty swallowing?
15. Yes ○ No ○ Diarrhea, constipation, blood in stools?
16. Yes ○ No ○ Frequent vomiting, nausea?
17. Yes ○ No ○ Difficulty urinating, blood in urine?
18. Yes ○ No ○ Dizziness?
19. Yes ○ No ○ Ringing in ears?
20. Yes ○ No ○ Headaches?
21. Yes ○ No ○ Fainting spells?
22. Yes ○ No ○ Blurred vision?
23. Yes ○ No ○ Seizures?
24. Yes ○ No ○ Excessive thirst?
25. Yes ○ No ○ Frequent urination?
26. Yes ○ No ○ Dry mouth?
27. Yes ○ No ○ Jaundice?
28. Yes ○ No ○ Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes ○ No ○ Heart disease?
30. Yes ○ No ○ Heart attack, heart defects?
31. Yes ○ No ○ Heart murmurs?
32. Yes ○ No ○ Rheumatic fever?
33. Yes ○ No ○ Stroke, hardening of arteries?
34. Yes ○ No ○ High blood pressure?
35. Yes ○ No ○ Asthma, TB, emphysema, other lung diseases?
36. Yes ○ No ○ Hepatitis, other liver disease?
37. Yes ○ No ○ Stomach problems, ulcers?
38. Yes ○ No ○ Allergies to: drugs, foods, medications, latex?
39. Yes ○ No ○ Family history of diabetes, heart problems, tumors?
40. Yes ○ No ○ AIDS
41. Yes ○ No ○ Tumors, cancer?
42. Yes ○ No ○ Arthritis, rheumatism?
43. Yes ○ No ○ Eye diseases?
44. Yes ○ No ○ Skin diseases?
45. Yes ○ No ○ Anemia?
46. Yes ○ No ○ VD (syphilis or gonorrhea)?
47. Yes ○ No ○ Herpes?
48. Yes ○ No ○ Kidney, bladder disease?
49. Yes ○ No ○ Thyroid, adrenal disease?
50. Yes ○ No ○ Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes ○ No ○ Psychiatric care?
52. Yes ○ No ○ Radiation treatments?
53. Yes ○ No ○ Chemotherapy?
54. Yes ○ No ○ Prosthetic heart valve?
55. Yes ○ No ○ Artificial joint?
56. Yes ○ No ○ Hospitalization?
57. Yes ○ No ○ Blood transfusions?
58. Yes ○ No ○ Surgeries?
59. Yes ○ No ○ Pacemaker?
60. Yes ○ No ○ Contact lenses?

V. ARE YOU TAKING:

61. Yes ○ No ○ Recreational drugs?
62. Yes ○ No ○ Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
63. Yes ○ No ○ Tobacco in any form?
64. Yes ○ No ○ Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65. Yes ○ No ○ Are you or could you be pregnant or nursing?
66. Yes ○ No ○ Taking birth control pills?

VII. ALL PATIENTS:

67. Yes ○ No ○ Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

RECALL REVIEW:

1. Patient's signature_____ Date:_____

2. Patient's signature_____ Date:_____

3. Patient's signature_____ Date:_____

Financial and Appointment Policy

Our Goal

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle and efficient manner. We are also here to help remove financial barriers so our patients can receive the dental treatment they need and desire. We are happy to provide patients with an estimate of costs prior to scheduling any treatment. Many patients have some type of dental insurance. In the majority of cases, we can assist you in maximizing your benefits. At your first visit, we will ask you for current insurance information. We may ask you to confirm this information at subsequent visits so we can remain up-to-date and fully informed to serve you. Insured patients will receive cost estimates broken down by insured and uninsured costs.

Since our practice is also a business with obligations that must be met, we ask that all patients pay their insurance co-pay in full on the day of service unless prior arrangements have been made.

Dental Insurance

We are in network with most PPO insurance companies. We are here to help if you have questions about your dental insurance. Your Human Resources Department may be able to answer questions as well. For patients covered by insurance, we will accept assignment of benefits. This means that you sign the portion of your insurance that "assigns" payment to our office. Most dental insurance plans do not cover 100% of the cost of your treatment. It is because of this, and the long delay in receiving payment from insurance companies, that you are asked to pay your deductible and your portion of charges at the time services are rendered. Please bring cash, check or credit card at the time of treatment.

All estimates are based on information provided to us by your insurance and are not a guarantee of payment. Only after a claim is submitted and reviewed by your insurance company can final payment be determined. As a courtesy to you, we file claim forms, handle special claims, and track claims for you. We will do our best to give you a rough cost estimate for each upcoming visit, based on your individual treatment plan. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate.

Appointment Policy

We only schedule one patient per appointment time because you deserve exclusive, personal time with our doctors and staff. We strive to run on time so you won't be kept waiting and we ask you to arrive for your appointments on time as well. We understand that you are busy, and your time is valuable to us! We pride ourselves on keeping to our schedule and only deviate from it in the event of dental emergencies.

Should you need to change or cancel your schedule appointment, we would appreciate the courtesy of being informed **at least 48 hours in advance.** Missed appointments without notification, or repeated cancellations, may incur a $50 fee. Last minute cancellations add to the cost of dental care when reserved facilities are left unused. We will gladly work with you to schedule convenient appointments for your visits to our office.

Agreement

I understand the financial and appointment policies and agree with this payment schedule as a method of payment for my treatment. I understand that I am responsible for my total dental cost regardless of any insurance coverage.

PRINT NAME:_____ date:_____

Signature _____ Date_____

HOW MAY WE CONTACT YOU TO CONFIRM YOUR APPOINTMENTS?

Name: _____

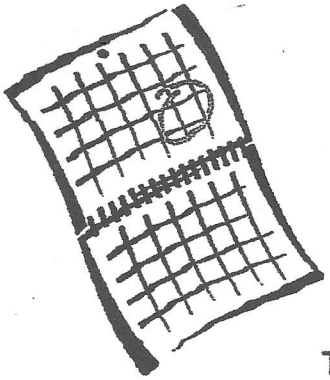
1. by Telephone? Primary Number: _____

Secondary Number: _____

2. by email? Email Address: _____

3. by text? Cell Number: _____

Cell Phone Carrier: _____



Thank you!